

1277 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>near, Cumberland, rural</u>				TOWN <u>near, Cumberland, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #1, Crystal Park</u>				STREET ADDRESS <u>R.F.D. #1, Crystal Park</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRED</u> (Middle) <u>HERSHEL</u> (Last) <u>ALBERT</u>				(Month) <u>February</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Mar. 7, 1890</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Conductor</u>		<u>B & O Railroad</u>		<u>Toms Brook, Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>CHARLES DAVID ALBERT</u>				<u>SARAH ELIZABETH RILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>705-07-1558</u>		<u>Route 1</u> <u>John A. Albert, Cumberland, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>2/12/56</u> , 19 <u>56</u> , to <u>2/13/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/12/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>50 Perry St. Cumberland, Md</u>		DATE SIGNED <u>2/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 16, 1956</u>		<u>Park Heights Cemetery</u>		<u>Brunswick, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 15, 1956</u>		<u>Winter R. Frantz, M.D.</u>		<u>John J. Hafer, Cumberland, Maryland</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF STATE CLERK

22. SIGNATURE OF U.S. MARSHAL

23. SIGNATURE OF U.S. ATTORNEY

24. SIGNATURE OF U.S. DISTRICT JUDGE

25. SIGNATURE OF U.S. SENATOR

26. SIGNATURE OF U.S. REPRESENTATIVE

27. SIGNATURE OF GOVERNOR

28. SIGNATURE OF VICE GOVERNOR

29. SIGNATURE OF COMMISSIONER OF HEALTH

30. SIGNATURE OF ASSISTANT COMMISSIONER

31. SIGNATURE OF CHIEF CLERK

32. SIGNATURE OF DEPUTY CHIEF CLERK

33. SIGNATURE OF RECORDS CLERK

34. SIGNATURE OF STATISTICS CLERK

35. SIGNATURE OF INSPECTION CLERK

36. SIGNATURE OF LABORATORY CLERK

37. SIGNATURE OF PHARMACY CLERK

38. SIGNATURE OF DENTISTRY CLERK

39. SIGNATURE OF OPTIC CLERK

40. SIGNATURE OF PODIATRY CLERK

41. SIGNATURE OF CHIROPY CLERK

42. SIGNATURE OF MASSAGE CLERK

43. SIGNATURE OF NURSING CLERK

44. SIGNATURE OF HEALTH EDUCATION CLERK

45. SIGNATURE OF PUBLIC HEALTH CLERK

46. SIGNATURE OF COMMUNITY CLERK

47. SIGNATURE OF ENVIRONMENTAL CLERK

48. SIGNATURE OF LABOR CLERK

49. SIGNATURE OF SAFETY CLERK

50. SIGNATURE OF FIRE CLERK

51. SIGNATURE OF POLICE CLERK

52. SIGNATURE OF JAIL CLERK

53. SIGNATURE OF COURT CLERK

54. SIGNATURE OF PROBATION CLERK

55. SIGNATURE OF PAROLE CLERK

56. SIGNATURE OF REFORMATORY CLERK

57. SIGNATURE OF INDUSTRIAL CLERK

58. SIGNATURE OF AGRICULTURE CLERK

59. SIGNATURE OF MINING CLERK

60. SIGNATURE OF FISHERY CLERK

61. SIGNATURE OF FORESTRY CLERK

62. SIGNATURE OF RAILROAD CLERK

63. SIGNATURE OF AIRCRAFT CLERK

64. SIGNATURE OF SPACE CLERK

BUREAU V. S.

FEB 16 1956

RECEIVED

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
 This certificate is to be filled out by the physician or other qualified person who has attended the deceased.
 It should be filled out as soon as possible after death, and before the body is buried or cremated.
 The information furnished on this certificate is used for the purpose of determining the cause of death and for the purpose of compiling statistics on the health of the State.
 The information furnished on this certificate is confidential and should not be disclosed to the public.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

01195

Reg. Dist. No. 4

1220

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		Yrs		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>815 Braddock Road</u>				STREET ADDRESS (If rural give location) <u>815 Braddock Road</u>			
3. NAME OF DECEASED (Type or Print) <u>FLORA MATILDA BLACKWELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 8 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>April 12, 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rosenbaum Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Rockwood, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry McElfish</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Bell Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-05-8258</u>		17. INFORMANT & ADDRESS <u>Minneapolis, Minn</u> <u>Mrs. Sarabelle Steele</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE (A) <u>Carcinoma of Pancreas</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> el work Not while <input type="checkbox"/> el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/5</u> , 19 <u>56</u> , to <u>7/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/8</u> , 19 <u>56</u> , and that death occurred at <u>5:10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Geo. S. Ley Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 452 N. Centre St Cumberland</u>		DATE SIGNED <u>7/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE HEREOF <u>Feb. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u>		LOCATION (City, town, or county) (State) <u>Allegany County, Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 11, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Date of death: _____
 3. Place of death: _____
 4. Cause of death: _____
 5. Manner of death: _____

6. Name of physician: _____
 7. Name of medical examiner: _____
 8. Name of coroner: _____
 9. Name of registrar: _____

10. Name of informant: _____
 11. Name of informant's address: _____
 12. Name of informant's occupation: _____
 13. Name of informant's relationship to deceased: _____

14. Name of informant's address: _____
 15. Name of informant's occupation: _____
 16. Name of informant's relationship to deceased: _____
 17. Name of informant's address: _____
 18. Name of informant's occupation: _____
 19. Name of informant's relationship to deceased: _____

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 BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01196

1278 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Route 1, Frostburg,</u>		<u>Lifetime</u>		OR TOWN <u>Route 1, Frostburg,</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John Andrew Blank</u>				<u>Feb. 8th, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct. 10th, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. Coal Miner</u>		<u>Coal Mining</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Blank</u>				<u>Elizabeth Frank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>220-10-2736</u>		<u>Route 1, Mrs. Barbara Blank, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Chronic myocarditis</u>						<u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B)						<u>1 1/2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<u>Chronic glomerular nephritis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>arterio-sclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-54</u>, 19<u>54</u>, to <u>2-8</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2-8</u>, 19<u>56</u>, and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H.C. Diehl</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>2/9/56</u>	
				M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-10-56</u>		<u>Zion Evang. Luth. Cemetery, Frostburg,</u>		<u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
		<u>John Stanley N. Rao</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			
DATE <u>2-10-56</u>							

RECEIVED

DR. REITER 1221 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE W.VA.		COUNTY HARDY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 2 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN MOOREFIELD, 85X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) BABY		(Middle) GIRL		(Last) BOEHN		FEBRUARY 12 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 2/10/1956	9. AGE last birthday yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Moorefield, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME GLADYS E. BOEHN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 776X Prematurity				INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 10, 19 56, to Feb 12, 19 56, that I last saw the deceased alive on Feb 12, 19 56, and that death occurred at 5:42A.M. from the causes and on the date stated above.							
SIGNATURE R. A. Reiter				ADDRESS (Street, city, town, state) M.D. 112 Belford St.		DATE SIGNED Feb 12, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE HEREOF Feb. 14, 1956		NAME OF CEMETERY OR CREMATORY Olivet Cemetery		LOCATION (City, town, or county) (State) Moorefield, West Virginia.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Winton R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Thushes Funeral Home		ADDRESS Moorefield, W. Va.	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01198

1279 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Route 1, Frostburg</u>		TOWN <u>Route 1, Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Arnold Brode</u>				<u>Feb 22 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 6th, 1889</u>	<u>66 yrs.</u>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Orderly</u>		<u>Sylvan Retreat</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Brode</u>				<u>Agnes Keirs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>212-12-8752</u>		<u>Route 1, Mrs. Hazel C. Brode, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>525X</u> IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				<u>6 mo</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1955</u>, 19 <u>Feb 21</u>, 19 <u>56</u>, to <u>Feb 22</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>Feb 21</u>, 19 <u>56</u>, and that death occurred at <u>10:35 A</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>WOM Lane</u>		<u>Frostburg Md</u>		<u>Feb 22 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2 - 24 - 56</u>		<u>F'bg. Memorial Park</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-24-56</u>		<u>Mrs. Nancy N. Roe</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. USUAL RESIDENCE PRIOR TO DECEASE

MARRIAGE

2. DATE OF DEATH

3. PLACE OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. SEX

7. AGE

8. OCCUPATION

9. EDUCATION

10. RELIGION

11. COLOR

12. BIRTH DATE

13. BIRTH PLACE

BUREAU V. S.

FEB 20 1936

RECEIVED

JOSEPH A. BURKE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO DO SO. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE PLACE AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE OR FOR THE RESULTS OF ANY ACTION TAKEN THEREON. THE REGISTRAR IS NOT TO BE HELD RESPONSIBLE FOR THE RESULTS OF ANY ACTION TAKEN THEREON.

1222

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>6 days</u>		TOWN <u>Cumberland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>125 Polk St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>D</u> (Last) <u>Buzzerd</u>				(Month) <u>2/</u> (Day) <u>15</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>10/19/ 99</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>ASST. Mgr.</u>			<u>Restaurant</u>		<u>W.VA. Elkins</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Denton S. Buzzerd</u>				<u>Elizabeth Weisman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>No.</u>			<u>268-07-4014</u>		<u>125 Polk St., Cumb. Md.</u>		
					<u>Pt's Chart Mrs. Helen Buzzerd</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
451X IMMEDIATE CAUSE (A)				<u>Dissecting aneurysm of aorta</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertension & Atherosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>1-2 years</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>January 15, 1955</u> , to <u>February 15, 1956</u> , that I last saw the deceased alive on <u>Feb. 15, 1956</u> , and that death occurred at <u>10:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>B. M. Schindler</u>				<u>41 Bennett Cumberland Md 2/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/18/56</u>		<u>S. S. Peter & Paul's</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Feb. 18, 1956</u>		<u>Walter L. Frantz, M.D.</u>		<u>Charles L. George Cumberland, Md.</u>			

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

01200
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural) Frostburg</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>(rural) Midlothian</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Miners Hospital.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
(Type or Print) <u>WILSON</u>		<u>Cecil</u> <u>Feb. 17</u> <u>19 56</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 9-1876</u>
9. AGE last birthday: <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer-Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Cresaptown, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>William Cecil</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Van Meter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>(son) William F. Cecil, Midlothian, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Myocardial failure	sudden
Antecedent cause(s)	(b) Chronic myocarditis	?
Diseases or conditions, if any, giving rise to the above cause	(c) Arteriosclerosis.	?
stating <u>underlying cause last</u>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Dening M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Feb. 18-195
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2 - 20- 56	Frostburg Memorial Park	Frostburg	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
2-20-56	Mr. Nancy A. Roe	Berish H. Winters	23 E. Main Frostburg, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 24 1956
BUREAU V. E.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01201

1267 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>47 TOWN Westernport</u>		LENGTH OF STAY (in this place) <u>5 Mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 Maryland Ave</u>				STREET ADDRESS (If rural give location) <u>123 Polk St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ida Katherine Cheuvront</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 5 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 17, 1874</u>		9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob H Harman</u>				14. MOTHER'S MAIDEN NAME <u>Anna R Kidwiler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Ruth C Collins Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Myocarditis and Myocardial Degeneration - from Not-specified as Rheumatic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gastric Ulcer</u>				<u>5 Months</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>None</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 10, 1955</u> , to <u>Feb. 5, 1956</u> , that I last saw the deceased alive on <u>Feb. 5, 1956</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont W. Va.</u>		DATE SIGNED <u>Feb 6 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>2-8-56</u>		REGISTRAR'S SIGNATURE <u>Margaret C Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc. Cumberland, Md.</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01202

Within corporate limits **1223** **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (In this place) 14 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 710 BEDFORD ST.			
3. NAME OF DECEASED (Type or Print) MILDRED N COAKLEY				4. DATE OF DEATH (Month) 2 (Day) 21 (Year) 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH DEC. 28, 1913	9. AGE last birthday 42 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee Factory			10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARVEY EVANS				14. MOTHER'S MAIDEN NAME BLANCHE CAMPBELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-5905		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) Carcinoma of Stomach						INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) (Cancer)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19 49 , to....., 19 56 , that I last saw the deceased alive on....., 19 56 , and that death occurred at 5:04 A.M. from the causes and on the date stated above. SIGNATURE ACG Weisman M.D. 598 Green St Cumberland Md 2/21/56 ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 24, 1956		NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		LOCATION (City, town, or county) (State) Hyndman, Pa.	
24. REC'D BY REGISTRAR DATE 2-23-56		REGISTRAR'S SIGNATURE Walter R. Pranty, MD		25. FUNERAL DIRECTOR'S SIGNATURE Harvey L. Zepher		ADDRESS Hyndman, Pa.	

CERTIFICATE OF DEATH

NAME OF DECEASED MILTON J. HARRIS		SEX MALE		AGE 45	
DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD.		RACE WHITE	
OCCUPATION LABORER		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED	
RESIDENCE 100 NORTH ST.		CITY BALTIMORE		COUNTY BALTIMORE	
DATE OF DEATH FEB 27 1956		PLACE OF DEATH HOSPITAL		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		MEDICAL OPINION NO SIGN OF INFECTION	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF DEATH REGISTRAR J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	

RECEIVED
FEB 27 1956
BUREAU V. 81

1
RECEIVED
BALTIMORE
MAY 1956
MILTON J. HARRIS
LABORER
BALTIMORE, MD.
JAN 15 1900
FEB 27 1956
HOSPITAL
HEART DISEASE
CORONARY THROMBOSIS
NO SIGN OF INFECTION
J. H. HARRIS
J. H. HARRIS
J. H. HARRIS

1224

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Allegany		STATE		Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		COUNTY		Allegany	
TOWN		Cumberland		CITY (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Allegany County Infirmary		TOWN		Cumberland	
STREET ADDRESS				STREET ADDRESS		320 Emily Street	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Elizabeth (Middle) Susan (Last) Cumiskey				(Month) February (Day) 10 (Year) 19 56			
5. SEX	6. RACE OR COLOR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widow	4/2/1876	79 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Maryland		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William McDonald				Madelyn Clay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Allegany County Infirmary			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170X IMMEDIATE CAUSE (A)				Pulmonary Hypostasis			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Cerebral Arteriosclerosis			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				Carcinoma Right Breast			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Metastases			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 23, 1954, to Feb. 10, 1956, that I last saw the deceased alive on Feb. 9, 1956, and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
James M. McLean				49 Greene St.		2-10-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/13/56		St. Peter & Paul Cemetery		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Feb. 11, 1956		Winter R. Hantz, M.D.		Louis Stein, Inc.		Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Registration No.

Place of Residence (House or Apartment)

City or Town

State

County

Age

Sex

Date of Death

Time of Death

Place of Death

Cause of Death

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BUREAU V. S.

FEB 15 1956

RECEIVED

EXCISE

1268

01204

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>5 days</u>		TOWN <u>Rural) Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rt. #2 - Box 277</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Thomas</u>		(Middle) <u>Cunningham</u>		(Last) <u>Cunningham</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Nov. 6 - 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Big Savage Ref. Co.</u>		9. AGE last birthday: <u>80</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Mt. Savage, Md.</u>	
13. FATHER'S NAME: <u>Patrick Cunningham</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Mattingly</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>215-07-3877</u>	
17. INFORMANT & ADDRESS: <u>John F. Cunningham & Hospital record</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION: <u>2</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Lobar pneumonia (right)</u>		DUE TO		<u>5 days</u>	
Antecedent cause(s) (b) <u>Cardiac hypertrophy</u>		DUE TO		<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Coronary sclerosis (marked)</u>		DUE TO		<u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>Feb. 18 - 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>2 - 20 - 56</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Michael's Catholic</u>	
LOCATION (City, town, or county) (State): <u>Frostburg Md.</u>		24. FUNERAL DIRECTOR		ADDRESS: <u>23 E. Main Frostburg, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2-20-56</u>		REGISTRAR'S SIGNATURE: <u>Mr. Nancy N. Roe</u>		24. FUNERAL DIRECTOR: <u>B.H. Wooten</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED

FEB 24 1951

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01205
Reg. Dist.

No. 14

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Ellerslie</u>		<u>1.1/2 yrs.</u>		TOWN <u>Ellerslie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Nancy</u>		<u>B.</u>		<u>Davey</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>female</u>		<u>white</u>		<u>widow</u>		<u>April 27-1889</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday:		11. BIRTHPLACE (State or foreign country):	
<u>housewife</u>		<u>Corn Name</u>		<u>66</u> yrs.		<u>Moorefield, W. Va.</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>John See</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>(brother) James See, Ellerslie, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO						<u>sudden</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>Arteriosclerosis also had</u> DUE TO						<u>?</u>	
(c) <u>Chronic myocarditis</u>						<u>several years.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>M.D.</u>		<u>Feb. 6-1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Feb. 9, 1956</u>		<u>Reston Cemetery</u>		<u>Ellerslie, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb. 7, 1956</u>		<u>J. Lloyd Wolfe</u>		<u>Harvey H. Beigler, Lyndon, Penna.</u>			

RECEIVED

FEB 15 1956

BUREAU V. S.

Within corporate limits.

1225

01206

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Cumberland

LENGTH OF STAY (In this place)

4 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Allegany

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN

Cumberland

(rural)

STREET ADDRESS

(If rural, give location)

Route #2 Williams Road.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Joseph

Alexander

Davis

4. DATE OF DEATH

(Month)

(Day)

(Year)

Feb.

14

19 56

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

male

white

single

Sept. 17-1935

20

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Service Mr.

10b. KIND OF BUSINESS OR INDUSTRY:

Natfield Tire S.

11. BIRTHPLACE (State or foreign country):

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Robert B. Davis

14. MOTHER'S MAIDEN NAME:

Nilda Donahoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

220-32-4965

17. INFORMANT & ADDRESS:

Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Contusion of brain

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Intracranial hemorrhage

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 days

4 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

Feb. 11/56

A.

M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Failed to negotiate a turn, hit utility pole & gas pumps.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

H.V. Deming M.D. M.D.

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
ASSISTANT MEDICAL EXAM.

DATE SIGNED

Feb. 14-1956

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Feb. 17, 1956

NAME OF CEMETERY OR CREMATORY

St. Peter and Paul Cem.

LOCATION (City, town, or county)

Cumberland, Maryland

(State)

DATE REC'D BY LOCAL REG.

Feb. 15, 1956

REGISTRAR'S SIGNATURE

Walter R. Franz, M.D.

24. FUNERAL DIRECTOR

Walter R. Franz, M.D.

ADDRESS

Walter R. Franz, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1933

BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1226 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>3 DAYS</u>		TOWN <u>CUMBERLAND, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>RT. #5, Cresap Park</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>LEONARD ELLSWORTH DIVELBLISS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 8, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>FEBRUARY 18, 1906</u>	
				9. AGE last birthday <u>49</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>C. A. Block employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN H. DIVELBLISS</u>				14. MOTHER'S MAIDEN NAME <u>KESECKER, MARY E.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-7313</u>		17. INFORMANT & ADDRESS <u>MEMORIAL HOSPITAL WARWICK AND MEMORIALS AVES.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.2 IMMEDIATE CAUSE (A) <u>Ventricular dilatation</u></u>						<u>1 wk</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/8/56</u>, 19<u>56</u>, to <u>2/8/56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/8/56</u>, 19<u>56</u>, and that death occurred at <u>5:40 P.</u>M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REG'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Hafer</u>		ADDRESS <u>Cumberland, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

01807

REG. NO. 10

2. MENTAL AND PHYSICAL CONDITION OF DECEASED

ALLIANCE

WYOMING

DECEASED

ALLIANCE

WYOMING, WY.

2 DAYS

CONVULSION

WYOMING HOSPITAL

OVERLIES

STAYED

LEAVES

WHITE

UNITED

FE BURY 1

U. S. A.

W. V.

KIDNEY, WY.

JOHN L. HAVELICK

WYOMING HOSPITAL
BALTIMORE, MD.

WY-05-05

BUREAU V. S.

FEB 15 1956

RECEIVED

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 01208

1269 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Frostburg				TOWN Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital				STREET ADDRESS (If rural give location) Allegany Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) Ada (Middle) Elizabeth (Last) Dohm				2/28/56 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	9/30/1878	77 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Berry				14. MOTHER'S MAIDEN NAME Hannah Guyman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. William C. Smith		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION Lonaconing, MD.		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Cerebral Vascular Accident						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Essential Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Congestive Heart failure							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-26, 1956, to 2-28, 1956, that I last saw the deceased alive on 2-28, 1956, and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
SIGNATURE Leslie R. Miles Jr. M.D.				ADDRESS (Street, city, town, state) Lonaconing Md.		DATE SIGNED 3-1-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/2/56		NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		LOCATION (City, town, or county) (State) Moscow, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Wm. Nancy N. Roe		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	
DATE 3-2-56							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES ALLEN		2. SEX Male		3. AGE 77	
4. PLACE OF BIRTH Maryland		5. DATE OF BIRTH 1879		6. PLACE OF DEATH Baltimore, Maryland	
7. OCCUPATION Retired		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		11. SIGNATURE OF REGISTRAR J. H. Smith		12. SIGNATURE OF DECEASED James Allen	
13. SIGNATURE OF WITNESSES J. H. Smith, M.D. J. H. Smith		14. SIGNATURE OF DECEASED James Allen		15. SIGNATURE OF DECEASED James Allen	

10-10-1956

TO THE CLERK OF THE DISTRICT COURT OF BALTIMORE, MD.

THE UNDERSIGNED, JAMES ALLEN, of the County of Baltimore, State of Maryland, do hereby certify that the foregoing is a true and correct copy of the original of the Certificate of Death of JAMES ALLEN, as the same appears from the records of the State Department of Health, Baltimore, Maryland.

WITNESSED my hand and seal of office this 10th day of October, 1956.

J. H. SMITH, REGISTRAR

RECEIVED

MAR 8 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1270 CERTIFICATE OF DEATH

01209

Reg. Dist. No. 9

Item 12 FilmG192 2-9-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>22 Frostburg</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>130 Mt. Pleasant St.</u>				STREET ADDRESS (If rural give location) <u>130 Mt. Pleasant St.</u>			
3. NAME OF DECEASED (Type or Print) <u>RAFFEALA TAVERNESE DORMIO</u>				4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>6-27-1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Kenneth Lowery, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Lymphatic Leukemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>	
ANTECEDENT CAUSE(S) DUE TO <u> </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u> </u>							
STATING UNDERLYING CAUSE LAST. DUE TO <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>Feb 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>Wm Lane</u>		DATE THEREOF <u>2-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		DATE SIGNED <u>2-1-56</u>	
DATE <u>2-2-56</u>		REGISTRAR'S SIGNATURE <u>Wm. Nancy A. Roe</u>		ADDRESS <u>J. R. Durst, Frostburg, Md.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Allegany		STATE	Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN		CITY (If outside corporate limits write RURAL and give nearest town)	TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
Ella Dye			Feb. 7 19 56		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
Female	white	Married	Dec. 16-1890		65 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):
Housewife			Clean Home		Md. U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Noble Foutz			Matilda Preston		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:
no			none		Memorial Hospital records.

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				about 17 min.	
Immediate cause (a) Myocardial failure				?	
Antecedent cause(s) (b) Coronary sclerosis				?	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Chronic myocarditis				?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Strangulated umbilical hernia.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Feb. 7-1956		Died on operating room table. Strangulated umbilical hernia, loops of ileum			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
H.V. Deming M.D.		H.V. Deming M.D.		Feb. 7-1956	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 10, 1956		Lafayette Hill Cemetery, Moscow, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Feb. 8, 1956		Walter R. Trautz, M.D.		E.S. Boal, Westernport, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 9 1956
BUREAU V. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1271

01211

Reg. Dist. No. 9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural, give location) <u>269 E. Main St.</u>			
3. NAME OF DECEASED: (First) <u>Rebecca</u>		(Middle) <u>C.</u>		(Last) <u>Eisel</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>3</u> (Year) <u>19 56</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>Sept. 2-1865</u>	9. AGE last birthday: <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Eckhart, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Close</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Dudley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>(son) George Eisel, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Interval Between Onset and Death	
450.0 Immediate cause (a) <u>Myocardial failure</u> DUE TO						Gradual	
Antecedent cause(s) (b) <u>Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of left femur.</u>						11 days	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>)		21c. (City or town) <u>Frostburg</u> (County) <u>Allegany</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 23/56 P. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Arose from couch and fell to the floor.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>H.V. Deming M.D.</u>		M. D. <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Feb. 5-1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) <u>Frostburg, Md</u> (State) <u> </u>	
DATE RECEIVED BY LOCAL REG. <u>2-7-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy A. Roe</u>		24. FUNERAL DIRECTOR <u>Nancy</u>		ADDRESS <u>23 E. Main, Frostburg, Md.</u>	

BUREAU V. S.

FEB 10 1956

RECEIVED

Within corporate limits

1228

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>				TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hosp.</u>				STREET ADDRESS (If rural give location) <u>411 Green St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Ferdinand</u>				(Month) <u>2-</u> (Day) <u>7</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 4, 1898</u>	<u>57 Yrs.</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Eckhart, Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Deitrick Saathoff</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>None</u>		<u>Cumberland, Md.</u> <u>Mr. Joseph Ferdinand 411 Greene St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary infarction</u>						<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 56</u> , to <u>Feb 7, 19 56</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. M. Dravaskis, Sr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland Maryland</u>			
DATE <u>Feb. 10, 1956</u>				DATE SIGNED <u>2/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/11/56</u>		<u>S. S. Peter & Pauls'</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Walter R. Dravaskis, M.D.</u>		<u>Charles L. George</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 1234

1. DECEASED PERSON'S NAME (Last, First, Middle)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. DATE OF REGISTRATION

16. TIME OF REGISTRATION

17. PLACE OF REGISTRATION

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF CLERK

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF WITNESS

22. DATE OF REGISTRATION

23. TIME OF REGISTRATION

24. PLACE OF REGISTRATION

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF CLERK

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF WITNESS

29. DATE OF REGISTRATION

30. TIME OF REGISTRATION

31. PLACE OF REGISTRATION

32. SIGNATURE OF REGISTRAR

33. SIGNATURE OF CLERK

34. SIGNATURE OF PHYSICIAN

35. SIGNATURE OF WITNESS

36. DATE OF REGISTRATION

37. TIME OF REGISTRATION

38. PLACE OF REGISTRATION

39. SIGNATURE OF REGISTRAR

40. SIGNATURE OF CLERK

41. SIGNATURE OF PHYSICIAN

42. SIGNATURE OF WITNESS

43. DATE OF REGISTRATION

44. TIME OF REGISTRATION

45. PLACE OF REGISTRATION

46. SIGNATURE OF REGISTRAR

47. SIGNATURE OF CLERK

48. SIGNATURE OF PHYSICIAN

49. SIGNATURE OF WITNESS

50. DATE OF REGISTRATION

51. TIME OF REGISTRATION

52. PLACE OF REGISTRATION

53. SIGNATURE OF REGISTRAR

54. SIGNATURE OF CLERK

55. SIGNATURE OF PHYSICIAN

56. SIGNATURE OF WITNESS

57. DATE OF REGISTRATION

58. TIME OF REGISTRATION

59. PLACE OF REGISTRATION

60. SIGNATURE OF REGISTRAR

61. SIGNATURE OF CLERK

62. SIGNATURE OF PHYSICIAN

63. SIGNATURE OF WITNESS

64. DATE OF REGISTRATION

65. TIME OF REGISTRATION

66. PLACE OF REGISTRATION

67. SIGNATURE OF REGISTRAR

68. SIGNATURE OF CLERK

69. SIGNATURE OF PHYSICIAN

70. SIGNATURE OF WITNESS

71. DATE OF REGISTRATION

72. TIME OF REGISTRATION

73. PLACE OF REGISTRATION

74. SIGNATURE OF REGISTRAR

75. SIGNATURE OF CLERK

76. SIGNATURE OF PHYSICIAN

77. SIGNATURE OF WITNESS

78. DATE OF REGISTRATION

79. TIME OF REGISTRATION

80. PLACE OF REGISTRATION

81. SIGNATURE OF REGISTRAR

82. SIGNATURE OF CLERK

83. SIGNATURE OF PHYSICIAN

84. SIGNATURE OF WITNESS

85. DATE OF REGISTRATION

86. TIME OF REGISTRATION

87. PLACE OF REGISTRATION

88. SIGNATURE OF REGISTRAR

89. SIGNATURE OF CLERK

90. SIGNATURE OF PHYSICIAN

91. SIGNATURE OF WITNESS

92. DATE OF REGISTRATION

93. TIME OF REGISTRATION

94. PLACE OF REGISTRATION

95. SIGNATURE OF REGISTRAR

96. SIGNATURE OF CLERK

97. SIGNATURE OF PHYSICIAN

98. SIGNATURE OF WITNESS

99. DATE OF REGISTRATION

100. TIME OF REGISTRATION

101. PLACE OF REGISTRATION

102. SIGNATURE OF REGISTRAR

103. SIGNATURE OF CLERK

104. SIGNATURE OF PHYSICIAN

105. SIGNATURE OF WITNESS

106. DATE OF REGISTRATION

107. TIME OF REGISTRATION

108. PLACE OF REGISTRATION

109. SIGNATURE OF REGISTRAR

110. SIGNATURE OF CLERK

111. SIGNATURE OF PHYSICIAN

112. SIGNATURE OF WITNESS

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114. TIME OF REGISTRATION

115. PLACE OF REGISTRATION

116. SIGNATURE OF REGISTRAR

117. SIGNATURE OF CLERK

118. SIGNATURE OF PHYSICIAN

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120. DATE OF REGISTRATION

121. TIME OF REGISTRATION

122. PLACE OF REGISTRATION

123. SIGNATURE OF REGISTRAR

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127. DATE OF REGISTRATION

128. TIME OF REGISTRATION

129. PLACE OF REGISTRATION

130. SIGNATURE OF REGISTRAR

131. SIGNATURE OF CLERK

132. SIGNATURE OF PHYSICIAN

133. SIGNATURE OF WITNESS

134. DATE OF REGISTRATION

135. TIME OF REGISTRATION

136. PLACE OF REGISTRATION

137. SIGNATURE OF REGISTRAR

138. SIGNATURE OF CLERK

139. SIGNATURE OF PHYSICIAN

140. SIGNATURE OF WITNESS

141. DATE OF REGISTRATION

142. TIME OF REGISTRATION

143. PLACE OF REGISTRATION

144. SIGNATURE OF REGISTRAR

145. SIGNATURE OF CLERK

146. SIGNATURE OF PHYSICIAN

147. SIGNATURE OF WITNESS

148. DATE OF REGISTRATION

149. TIME OF REGISTRATION

150. PLACE OF REGISTRATION

151. SIGNATURE OF REGISTRAR

152. SIGNATURE OF CLERK

153. SIGNATURE OF PHYSICIAN

154. SIGNATURE OF WITNESS

155. DATE OF REGISTRATION

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229. SIGNATURE OF CLERK

230. SIGNATURE OF PHYSICIAN

231. SIGNATURE OF WITNESS

232. DATE OF REGISTRATION

233. TIME OF REGISTRATION

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235. SIGNATURE OF REGISTRAR

236. SIGNATURE OF CLERK

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240. TIME OF REGISTRATION

241. PLACE OF REGISTRATION

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250. SIGNATURE OF CLERK

251. SIGNATURE OF PHYSICIAN

252. SIGNATURE OF WITNESS

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254. TIME OF REGISTRATION

255. PLACE OF REGISTRATION

256. SIGNATURE OF REGISTRAR

257. SIGNATURE OF CLERK

258. SIGNATURE OF PHYSICIAN

259. SIGNATURE OF WITNESS

260. DATE OF REGISTRATION

261. TIME OF REGISTRATION

262. PLACE OF REGISTRATION

263. SIGNATURE OF REGISTRAR

264. SIGNATURE OF CLERK

1229

01213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE W. Va. COUNTY Mineral
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Wiley Ford
STREET ADDRESS (If rural, give location) Reed's Hill

3. NAME OF DECEASED:

(First) Thomas (Middle) Roy (Last) Files

4. DATE OF DEATH (Month) (Day) (Year) Feb. 19 1956

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH:

Nov. 27-1893

9. AGE last birthday:

62 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired.) Asst. Supervisor of Carmen-B&O.R.Ry.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Shockeyville, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Jacob Files

14. MOTHER'S MAIDEN NAME:

Sarah C. Dailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W.I

16. SOCIAL SECURITY No.: 705-05-7739

17. INFORMANT & ADDRESS: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

902.6
Immediate cause

(a) Fracture of 7th. cervical vertebrae with
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) spinal cord injury and quadraplegia.
DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) Wiley Ford

21c. (City or town) (County) (State) Mineral W. Va.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Feb. 14-1956 A.M.

21e. INJURY OCCURRED While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR? Caught foot on scaffolding board & fell to ground.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H. V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Feb. 19-1956
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 2-22-1956

NAME OF CEMETERY OR CREMATORY Snyders Chapel Cem.

LOCATION (City, town, or county) (State) Near Johnstown, W. Va.

DATE REC'D BY LOCAL REG. Feb. 20, 1956

REGISTRAR'S SIGNATURE Winter R. Frank, M.D.

24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 21 1934

RECEIVED

1230

CERTIFICATE OF DEATH

Within corporate limits

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Cumberland</u>		<u>1/2</u> hr.		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>15 Market Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>M</u> (Last) <u>Fradiska</u>				(Month) <u>2</u> (Day) <u>10</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Jan. 22, 1889</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Custodian</u>		<u>American Legion</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Michael Fradiska</u>				<u>Anna Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>War I</u>		<u>Son</u> <u>Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Coronary Occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Recent myocardial Infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Coronary Heart Disease</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>None</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
		<u>None</u>		<u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>None</u>							
22. I hereby certify that I attended the deceased from <u>Feb 10, 1956</u> , to <u>Feb 10, 1956</u> , that I last saw the deceased alive on <u>Feb 10, 1956</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Hallenon MD</u>				ADDRESS (Street, city, town, state) <u>140 Bedford St. Cumberland, Md.</u>		DATE SIGNED <u>2-10-1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/13/56</u>		<u>St. Peter & Paul</u>		<u>Cumberland, Md.</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 11, 1956</u>		<u>Walter R. Hantz, M.D.</u>		<u>Louis Stein, Inc.</u>		<u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Race

5. Date of birth

6. Place of birth

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of witness

14. Signature of witness

15. Signature of witness

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BUREAU V. S.

FEB 15 1956

RECEIVED

01215

1231 CERTIFICATE OF DEATH

DR. RANSOM

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		12 HRS. 36 MIN.		TOWN CUMBERLAND, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
MEMORIAL HOSPITAL				RT. #4, WILLOWBROOK ROAD			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
BABY GIRL FRIEND				FEBRUARY 22, 19 56			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
FEMALE		WHITE		SINGLE		FEBRUARY 21, 1956	
						9. AGE last birthday	
						IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
						12 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE						CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ELIJAH JUNIOR FRIEND				BEULAH J. MULLENAX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
NO				NONE		MEMORIAL HOSPITAL - CUMBERLAND, MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
774X Respiratory Insufficiency						6 hours	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 22 Feb, 19 56, to 22 Feb, 19 56, that I last saw the deceased alive on 22 Feb, 19 56, and that death occurred at 1:00A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Leland Ransom M.D.				636 Green St. Cumb. Md		23 Feb 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/24/1956		Deer Park Cemetery		Deer Park, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Feb 24, 1956		Winter R. Frantz, M.D.		Wm. H. Kight		Cumberland, Md.	

VS AISC 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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FEB 27 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>6 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>925 Grand Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Patricia Kathleen Glaze</u>				<u>Feb. 15 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>single</u>	<u>Jan. 22-1953</u>	<u>3 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Albuquerque, New Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Walter Glaze</u>				14. MOTHER'S MAIDEN NAME: <u>Loretta Collier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>M.H. Records also (father) Walter Glaze, Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						3 days.	
Immediate cause (a) <u>Cerebral Hemorrhage (mild-circle of Willis)</u>							
DUE TO <u>Cerebral edema</u>							
Antecedent cause(s) (b) <u>Mucus plugs in lungs</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u>Malnutrition</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>2</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		(State)	
		M.					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		H.V. Deming M.D.		H. V. Deming M.D.		M. D. DATE SIGNED <u>Feb. 15-1956</u>	
CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Feb. 17, 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>Green Spring Cemetery</u>		LOCATION (City, town, or county) (State): <u>Green Spring, West Virginia</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb. 17, 1956</u>		<u>Walter R. Franz, M.D.</u>		<u>James P. Carbell</u>		<u>Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 20 1956

BUREAU V. S.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1282 **CERTIFICATE OF DEATH**

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Barton</u>		<u>66 yrs</u>		TOWN <u>Barton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>Hamilton</u> (Last) <u>Guynn</u>				(Month) <u>Feb</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>16 January 1890</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Miner - ret</u>		<u>Coal Mine</u>		<u>Barton, Md.</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Guynn</u>				<u>Hannah Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>212-03-3842</u>		<u>Mrs William H. Guynn, Barton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>523.0</u> IMMEDIATE CAUSE (A) <u>Chronic Bronchitis with Asthma caused by Silicosis and anthracosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Lobar Pneumonitis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>None</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 10</u> , 19 <u>51</u> , to <u>Feb 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>56</u> , and that death occurred at <u>8:00 A</u> .M., from the causes and on the date stated above.							
SIGNATURE <u>Paul R Wilson</u>				ADDRESS (Street, city, town, state) <u>Piedmont, W. Va</u>		DATE SIGNED <u>Feb 18, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>19 Feb 56</u>		<u>Laurel Hill Cemetery</u>		<u>Moscow, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2-18-57</u>		<u>Mr. Jean C Kelly</u>		<u>E. J. Boral</u>		<u>Westernport, Md.</u>	

BUREAU V. S.

FEB 20 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				01218	
1283				Reg. Dist. No. 4	
1. PLACE OF DEATH COUNTY <u>Allegany</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rt. # 6 Cumberland,</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Rt. 220 Bowling Green</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rt. # 6 Cumberland,</u> STREET ADDRESS (If rural give location) <u>U. S. Rt. 220 Bowling Green</u>		
3. NAME OF DECEASED: (Type or Print) <u>CHARLES WILLIAM HAMMON</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 8, 1956</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 14, 1873</u>		9. AGE last birthday <u>82</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Track Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>B. & O. Rwy.</u>		11. BIRTHPLACE (State or foreign country): <u>Cumberland, Maryland</u>	
13. FATHER'S NAME: <u>Andrew Hammon</u>			14. MOTHER'S MAIDEN NAME: <u>Eva. Beckett</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No,</u>			17. INFORMANT & ADDRESS: <u>Mrs. Fred Walton Rt. # 6 Cumberland, Md.</u>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Hypertensive arterio sclerosis</u>					
ANTECEDENT CAUSE (S) (B) <u>Vascular disease</u>					<u>Since 2/10/49.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2.10.</u> , 19 <u>44</u> to <u>2.8.</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1.30.</u> , 19 <u>56</u> , and that death occurred at <u>4P</u> M., from the causes and on the date stated above. SIGNATURE <u>W. F. Williams</u> M. D. <u>Cumberland</u> DATE SIGNED <u>2.9.56</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 11, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		24. FUNERAL DIRECTOR ADDRESS <u>H. Wayne George Cumberland, Md.</u>	

BUREAU V. S.

FEB 15 1936

RECEIVED

Mr. Stapp -

1233

CERTIFICATE OF DEATH

01219

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Morgan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				d. STREET ADDRESS PAW PAW 95X-3			
3. NAME OF DECEASED (Type or print) First SARAH Middle VIOLA Last HANLIN				4. DATE OF DEATH Month FEBRUARY Day 29 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 3, 1904	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) GRANT COUNTY, W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HERMAN BOBO				14. MOTHER'S MAIDEN NAME ALICE ROADCAP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Memorial Hospital Cumberland Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis (uremia) DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis (stone in common duct) 2/20/56 INTERVAL BETWEEN ONSET AND DEATH One year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2.13.1956 to 2.29.1956 that I last saw the deceased alive on FEB. 29 , 1956, and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 3-2-56							
ACTUAL SIGNATURE Wm. F. Williams M.D.							
PHYSICIAN'S NAME (Type) William F. Williams							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-56		22c. NAME OF CEMETERY OR CREMATORY Pine Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hardy County West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumberland Maryland				24a. REC'D BY REGISTRAR March 3, 1956		24b. REGISTRAR'S SIGNATURE W.L. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01220

1234 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>16 days</u>		TOWN <u>Cresaptown</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS <u>124x24x10x8x Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Carried</u> <u>Harrison</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2/</u> <u>21/</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/28/06</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Cresaptown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George McKenzie</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hershberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
163X IMMEDIATE CAUSE (A) <u>Cancer of Lung</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-20-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>carcinoma of right upper lobe</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-20-55</u> to <u>2-21-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-21-</u> , 19 <u>56</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>L. Phinizy</u> M.D. <u>57 Greene St. Cumberland Md</u> DATE SIGNED <u>2-22-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 24, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cresaptown, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb. 25, 1956</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Dist. No.

A. GRAVE RESEARCH (HONOR OF RECORD)

REG. DIST. NO.

MARRIAGE

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NOTIFICATION

NOTIFICATION OF DEATH TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA, D.C. FOR THE PURPOSE OF RECORDING THE DEATH AND ISSUING A DEATH CERTIFICATE. THE DEATH CERTIFICATE IS A LEGAL DOCUMENT WHICH IS REQUIRED FOR THE PURPOSES OF BURIAL, CREMATION, OR OTHER DISPOSAL OF THE BODY. IT IS ALSO REQUIRED FOR THE PURPOSES OF OBTAINING LIFE INSURANCE PAYOUTS, VETERAN'S BENEFITS, AND OTHER FINANCIAL MATTERS. THE DEATH CERTIFICATE IS VALID FOR A PERIOD OF FIVE YEARS FROM THE DATE OF ISSUANCE. IF THE DEATH CERTIFICATE IS NOT USED WITHIN THIS PERIOD, IT WILL BE CONSIDERED VOID. THE DEATH CERTIFICATE IS A LEGAL DOCUMENT WHICH IS REQUIRED FOR THE PURPOSES OF BURIAL, CREMATION, OR OTHER DISPOSAL OF THE BODY. IT IS ALSO REQUIRED FOR THE PURPOSES OF OBTAINING LIFE INSURANCE PAYOUTS, VETERAN'S BENEFITS, AND OTHER FINANCIAL MATTERS. THE DEATH CERTIFICATE IS VALID FOR A PERIOD OF FIVE YEARS FROM THE DATE OF ISSUANCE. IF THE DEATH CERTIFICATE IS NOT USED WITHIN THIS PERIOD, IT WILL BE CONSIDERED VOID.

BUREAU V. S.

FEB 29 1951

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01221

Within corporate limits

1235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY ALLEGANY MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY ALLEGANY CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND STREET ADDRESS 117 LAING AVENUE			
3. NAME OF DECEASED (Type or Print) ROBERT WAYNE HENDERSHOT JR.			4. DATE OF DEATH (Month) 2 (Day) 21 (Year) 1956				
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Child	8. DATE OF BIRTH 7-8-55		9. AGE last birthday yrs. 7 Months 13 Days 13		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.			
13. FATHER'S NAME ROBERT L. HENDERSHOT			14. MOTHER'S MAIDEN NAME DORIS STEVENSON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 0850 IMMEDIATE CAUSE (A) Measles				INTERVAL BETWEEN ONSET AND DEATH 2/19/56			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Toxic Convulsions				2/20/56			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-15-56 , to 2-20-56 , that I last saw the deceased alive on 2-20-56 , and that death occurred at 12:02 A.M. from the causes and on the date stated above. SIGNATURE N. W. Eason M.D. 126 W. 4th St. Cumberland Md DATE SIGNED 2/21/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 23, 1956		NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			
24. REC'D BY REGISTRAR 2-23-56		REGISTRAR'S SIGNATURE Therese R. Grant		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer			
DATE 2-23-56		ADDRESS (City, town, or county) Cumberland Md		ADDRESS			

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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DEATH CERTIFICATE OF DEATH

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FEB 27 1956

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1236

CERTIFICATE OF DEATH

012224
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u> <u>02</u>		d. STREET ADDRESS <u>222 Springdale St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>222 Springdale St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nettie May Rockwell House</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 28, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1873</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Greenridge, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lemuel Rockwell</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Northcraft</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edgar J. House, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenoma Carcinoma of</u> <u>body of uterus & invasion of the Cervix</u> DUE TO (b) <u>Hypertensive arteriosclerosis</u> DUE TO (c) <u>vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>3. 19. 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3. 19. 1956</u> to <u>2. 28. 1956</u> that I last saw the deceased alive on <u>2. 26. 1956</u> , and that death occurred at <u>3. 0. 1956</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>W. F. Williams, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>W. F. Williams, M. D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 1, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		24a. REC'D BY REGISTRAR <u>2. 29. 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>W. F. Williams, M.D.</u>		24c. REGISTRAR'S SIGNATURE <u>W. F. Williams, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		HOSPITAL		PHYSICIAN	
DISEASE		SYMPTOMS		TREATMENT		PROGNOSIS		PATHOLOGICAL FINDINGS		LABORATORY EXAMINATIONS		POST-MORTEM		BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL	

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1237 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		LENGTH OF STAY (in this place) 20 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) R. F. D. #1			
3. NAME OF DECEASED (Type or Print) THOMAS S. HOWATT				4. DATE OF DEATH (Month) FEB. 8 (Day) 19 (Year) 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH APRIL 9, 1889	9. AGE last birthday 66 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROBERT HOWATT				14. MOTHER'S MAIDEN NAME JANET CARMICHAEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes W. W. I.		16. SOCIAL SECURITY NO. W. W. I.		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVE.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage with left				4 weeks			
ANTECEDENT CAUSE(S) DUE TO (B) Hemiplegia							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hemiplegia with weakness							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Sclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12:50 PM, 1956, to 8:17 PM, 1956, that I last saw the deceased alive on 8 Feb., 1956, and that death occurred at 1:55 PM, from the causes and on the date stated above.							
SIGNATURE W. A. V. C. Ormer				ADDRESS (Street, city, town, state) Cumberland, Md.			
DATE SIGNED 9 Feb. 56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 11, 1956		NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Maryland.	
24. REC'D BY REGISTRAR Feb. 9, 1956		REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1272 CERTIFICATE OF DEATH

01224

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>				TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 East Main Street</u>				STREET ADDRESS (If rural give location) <u>90 East Main</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Helen</u> (Middle) <u>Wayne</u> (Last) <u>Irons</u>				(Month) <u>2</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Married</u>	<u>Aug. 1st, 1915</u>	<u>40</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Frostburg</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles O. Atkinson</u>				<u>Margaret Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>217 - 10 - 1086</u>		<u>90 E. Main</u> <u>Mr. Leo Irons Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163X IMMEDIATE CAUSE (A) <u>Transition</u>						<u>1 month</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA OF LUNG</u>						<u>6 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>10/14</u> , 19 <u>55</u> , to <u>2/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/3</u> , 19 <u>56</u> , and that death occurred at <u>12 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John C. Demers</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>2/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2 - 7 - 56</u>		<u>Frostburg Memorial Park Frostburg</u>		<u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-7-56</u>		<u>Wm. Nancy H. Rae</u>		<u>Buried H. Monticourt</u>		<u>23 E. Main Frostburg, Md.</u>	

1920 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

REG. NO. 100-10000

1. NAME OF DECEASED

HAWAIIAN

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

BUREAU V. S.

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1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. CAUSE OF DEATH
7. SIGNATURE OF REGISTRAR
8. SIGNATURE OF DECEASED
9. SIGNATURE OF WITNESSES
10. SIGNATURE OF FUNERAL HOME
11. SIGNATURE OF CHURCH
12. SIGNATURE OF OTHER

1238 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		2 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				317 WASHINGTON ST.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
CLARE Angela KEAN				FEBRUARY 8, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	SINGLE	MAY 2, 1887	68 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired Secretary			Retail Paint Store		Cumberland MARYLAND		U. S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DANIEL E. KEAN				MARY C. Landwehr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No.		214-05-9478		Cumberland, Md. Mrs. Helen McDonough 317 Washington St.,			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
CONCUSSION OF BRAIN						60 Days	
ANTECEDENT CAUSE(S) DUE TO (B)						2 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. at work <input type="checkbox"/> et work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Oct 1, 1956, to Feb 8, 1956, that I last saw the deceased alive on Feb 8, 1956, and that death occurred at 12:40 PM from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
L. McGehee				M. D. 44 Green St		2/10/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		2/11/56		S. S. Peter & Paul's		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE February 14, 1956		Walter R. Grant, M.D.		Charles L. George Cumberland, Md.			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1284

CERTIFICATE OF DEATH

01226

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Md.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nikep</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nikep</u>	
TOWN <u>Nikep</u>		LENGTH OF STAY (in this place) <u>37</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First) <u>Agnes</u> (Middle) <u>May</u> (Last) <u>Kiddy</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 8, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Alderdice</u>				14. MOTHER'S MAIDEN NAME <u>Janet Bulloch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>00-000000000</u>		17. INFORMANT & ADDRESS <u>John R. Kiddy-Nikep, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				108			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congestive Heart failure</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1952</u> to <u>2/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>56</u> , and that death occurred at <u>1:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Serge Richard</u> M.D.		ADDRESS (Street, city, town, state) <u>Lonaconing, Md.</u>		DATE SIGNED <u>2-8-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/10/56</u>	NAME OF CEMETERY OR CREMATORY <u>Oak-Hill</u>		LOCATION (City, town, or county) <u>Lonaconing</u>		(State) <u>Md.</u>	
24. REC'D BY REGISTRAR <u>2-9-56</u>	REGISTRAR'S SIGNATURE <u>Janet M. Boal</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>El. Boal</u>		ADDRESS <u>Westernport, Md.</u>			

BUREAU V. S.

FEB 14 1936

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01227

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>63 yrs.</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Memorial Hospital.</u>				STREET ADDRESS (If rural, give location) <u>625 Columbia Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Walter Frederick Kiiffner</u>				<u>Feb. 26 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>divorced</u>	<u>Dec. 3-1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Clerk - Heinrich Clothing Store.</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Cumberland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>John Kiiffner</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Schafer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>220-10-9017</u>			
				17. INFORMANT & ADDRESS: <u>Mrs. Henry Kiiffner, Cumberland, Md.</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u>						<u>sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Coronary sclerosis</u>						<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:						19b. MAJOR FINDING OF OPERATION:	
						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
<u>H. V. Deming M.D.</u>		<u>H. V. Deming M.D.</u>		<u>M. D.</u>		<u>Feb. 27-1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 29 1956</u>		<u>St. Mary's Lutheran Cem.</u>		<u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb. 28, 1956</u>		<u>Walter R. Hantz, M.D.</u>		<u>H. Lee Silcox</u>		<u>" "</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01228

1285 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH COUNTY Allegany MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Dawson TOWN Dawson HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) Dawson TOWN Dawson STREET ADDRESS (If rural give location) X			
3. NAME OF DECEASED (Type or Print) (First) Jasper (Middle) Allen (Last) Kimble			4. DATE OF DEATH (Month) Feb. (Day) 29, (Year) 19 56				
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 27, 1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY W. Md. R. R. Co.		11. BIRTHPLACE (State or foreign country) Ketterman, W. Va.			
13. FATHER'S NAME William Wesley Kimble			14. MOTHER'S MAIDEN NAME Fannie McDonald				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Kella R. Kimble			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 581.0 IMMEDIATE CAUSE (A) Cirrhosis Liver ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 6 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 50 , to Feb 29, 19 56 , that I last saw the deceased alive on Feb 28, 19 56 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. SIGNATURE [Signature] M.D. [Signature] DATE SIGNED 31-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-3-56		NAME OF CEMETERY OR CREMATORY Dawson Cemetery			
24. REC'D BY REGISTRAR DATE 3-2-56		REGISTRAR'S SIGNATURE Mrs Jean C. Kelly		25. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home ADDRESS Keyser, Md. Va.			

0155

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1952 CERTIFICATE OF DEATH

1. NAME OF DECEASED Allison		2. SEX Male	
3. DATE OF BIRTH Jan. 23, 1900		4. PLACE OF BIRTH Baltimore, Md.	
5. OCCUPATION None		6. CAUSE OF DEATH Heart Disease	
7. DATE OF DEATH Mar. 5, 1952		8. PLACE OF DEATH Home	
9. SIGNATURE OF DECEASED		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	

BUREAU V. S.

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The undersigned, being a duly qualified and sworn health officer, do hereby certify that the foregoing is a true and correct copy of the original certificate of death filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 5th day of March, 1952.

Item 18 Film G193 3-13-56 ams

1240 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		10/19/55		TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 110 South Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Kate Sheffer (Middle) (Last) Kolb				(Month) (Day) (Year) Feb. 24, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widow	3/21/1871	84 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mt. Savage, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Wade Cook				14. MOTHER'S MAIDEN NAME Georgeanna Plummer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II carcinomatosis				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Nephritis				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 28, 1955, to Feb. 24, 1956, that I last saw the deceased alive on Feb. 23, 1956, and that death occurred at 12:27 P.M. from the causes and on the date stated above.							
SIGNATURE James F. Scarfelli M.D.				ADDRESS (Street, city, town, state) 49 Precinct St. Cumberland, Md.		DATE SIGNED 2-24-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-27-56		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Cumberland, Md.	
24. REC'D BY REGISTRAR Feb. 27, 1956		REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarfelli ADDRESS Cumberland, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1.5. *Experiments*

22/02/05

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2. *Environ Biol Fish* (2008) 81:111–120

26:186208

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BUREAU V. 8

FEB 29 1956

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1241 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 4 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FROSTBURG			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.				STREET ADDRESS (If rural give location) 164 E COLLEGE AVE.			
3. NAME OF DECEASED (Type or Print) IRVIN P. KYLE				4. DATE OF DEATH (Month) (Day) (Year) FEB. 9. 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH NOV. 25 1892	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese worker		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp		11. BIRTHPLACE (State or foreign country) MARYLAND (Barton)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE KYLE				14. MOTHER'S MAIDEN NAME NETTIE MC INTYRE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-07-5546		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL CUMBERLAND MD			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 570.3 IMMEDIATE CAUSE (A) Valvular Cecum with obstruction						4 days	
ANTECEDENT CAUSE(S) DUE TO (B) Valvular heart disease						1 year +	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Probable mesenteric embolus						24 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION Feb 6 1956		19b. MAJOR FINDINGS OF OPERATION valvular Cecum with obstruction				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 5, 1956, to Feb 9, 1956, that I last saw the deceased alive on Feb 9, 1956, and that death occurred at 2:25 PM, from the causes and on the date stated above.							
SIGNATURE Wm J. Law Jr				ADDRESS (Street, city, town, state) Cumberland Md		DATE SIGNED Feb 9 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2 - 12 - 56		NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Md.	
24. REC'D BY REGISTRAR Feb 12 1956		REGISTRAR'S SIGNATURE Walter S. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE R. H. Montross		ADDRESS 23 E. Main Frostburg, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 17

Reg. Dist. No.

1. DECEASED'S RESIDENCE (Street or Post Office)

2. DECEASED'S NAME (Last, First, Middle)

3. DECEASED'S SEX

4. DECEASED'S AGE

5. DECEASED'S OCCUPATION

6. DECEASED'S BIRTH DATE

7. DECEASED'S BIRTH PLACE

8. DECEASED'S RACE

9. DECEASED'S COLOR

10. DECEASED'S MARRIAGE STATUS

11. DECEASED'S EDUCATION

12. DECEASED'S RELIGION

13. DECEASED'S SERVICE

14. DECEASED'S DATE OF DEATH

15. DECEASED'S TIME OF DEATH

16. DECEASED'S PLACE OF DEATH

17. DECEASED'S CAUSE OF DEATH

18. DECEASED'S MANNER OF DEATH

19. DECEASED'S SIGNATURE

20. DECEASED'S ADDRESS

21. DECEASED'S CITY

22. DECEASED'S COUNTY

23. DECEASED'S STATE

24. DECEASED'S ZIP CODE

25. DECEASED'S PHONE NUMBER

26. DECEASED'S SOCIAL SECURITY NUMBER

27. DECEASED'S MARITAL STATUS

28. DECEASED'S OCCUPATION

29. DECEASED'S EDUCATION

30. DECEASED'S RELIGION

31. DECEASED'S SERVICE

32. DECEASED'S DATE OF DEATH

33. DECEASED'S TIME OF DEATH

34. DECEASED'S PLACE OF DEATH

35. DECEASED'S CAUSE OF DEATH

36. DECEASED'S MANNER OF DEATH

37. DECEASED'S SIGNATURE

38. DECEASED'S ADDRESS

39. DECEASED'S CITY

40. DECEASED'S COUNTY

41. DECEASED'S STATE

42. DECEASED'S ZIP CODE

43. DECEASED'S PHONE NUMBER

44. DECEASED'S SOCIAL SECURITY NUMBER

45. DECEASED'S MARITAL STATUS

46. DECEASED'S OCCUPATION

47. DECEASED'S EDUCATION

48. DECEASED'S RELIGION

49. DECEASED'S SERVICE

50. DECEASED'S DATE OF DEATH

51. DECEASED'S TIME OF DEATH

52. DECEASED'S PLACE OF DEATH

53. DECEASED'S CAUSE OF DEATH

54. DECEASED'S MANNER OF DEATH

55. DECEASED'S SIGNATURE

56. DECEASED'S ADDRESS

57. DECEASED'S CITY

58. DECEASED'S COUNTY

59. DECEASED'S STATE

60. DECEASED'S ZIP CODE

61. DECEASED'S PHONE NUMBER

62. DECEASED'S SOCIAL SECURITY NUMBER

63. DECEASED'S MARITAL STATUS

64. DECEASED'S OCCUPATION

65. DECEASED'S EDUCATION

66. DECEASED'S RELIGION

67. DECEASED'S SERVICE

68. DECEASED'S DATE OF DEATH

69. DECEASED'S TIME OF DEATH

70. DECEASED'S PLACE OF DEATH

71. DECEASED'S CAUSE OF DEATH

72. DECEASED'S MANNER OF DEATH

73. DECEASED'S SIGNATURE

74. DECEASED'S ADDRESS

75. DECEASED'S CITY

76. DECEASED'S COUNTY

77. DECEASED'S STATE

78. DECEASED'S ZIP CODE

79. DECEASED'S PHONE NUMBER

80. DECEASED'S SOCIAL SECURITY NUMBER

81. DECEASED'S MARITAL STATUS

82. DECEASED'S OCCUPATION

83. DECEASED'S EDUCATION

84. DECEASED'S RELIGION

85. DECEASED'S SERVICE

86. DECEASED'S DATE OF DEATH

87. DECEASED'S TIME OF DEATH

88. DECEASED'S PLACE OF DEATH

89. DECEASED'S CAUSE OF DEATH

90. DECEASED'S MANNER OF DEATH

91. DECEASED'S SIGNATURE

92. DECEASED'S ADDRESS

93. DECEASED'S CITY

94. DECEASED'S COUNTY

95. DECEASED'S STATE

96. DECEASED'S ZIP CODE

97. DECEASED'S PHONE NUMBER

98. DECEASED'S SOCIAL SECURITY NUMBER

99. DECEASED'S MARITAL STATUS

100. DECEASED'S OCCUPATION

101. DECEASED'S EDUCATION

102. DECEASED'S RELIGION

103. DECEASED'S SERVICE

104. DECEASED'S DATE OF DEATH

105. DECEASED'S TIME OF DEATH

106. DECEASED'S PLACE OF DEATH

107. DECEASED'S CAUSE OF DEATH

108. DECEASED'S MANNER OF DEATH

109. DECEASED'S SIGNATURE

110. DECEASED'S ADDRESS

111. DECEASED'S CITY

112. DECEASED'S COUNTY

113. DECEASED'S STATE

114. DECEASED'S ZIP CODE

115. DECEASED'S PHONE NUMBER

116. DECEASED'S SOCIAL SECURITY NUMBER

117. DECEASED'S MARITAL STATUS

118. DECEASED'S OCCUPATION

119. DECEASED'S EDUCATION

120. DECEASED'S RELIGION

121. DECEASED'S SERVICE

122. DECEASED'S DATE OF DEATH

123. DECEASED'S TIME OF DEATH

124. DECEASED'S PLACE OF DEATH

125. DECEASED'S CAUSE OF DEATH

126. DECEASED'S MANNER OF DEATH

127. DECEASED'S SIGNATURE

128. DECEASED'S ADDRESS

129. DECEASED'S CITY

130. DECEASED'S COUNTY

131. DECEASED'S STATE

132. DECEASED'S ZIP CODE

133. DECEASED'S PHONE NUMBER

134. DECEASED'S SOCIAL SECURITY NUMBER

135. DECEASED'S MARITAL STATUS

136. DECEASED'S OCCUPATION

137. DECEASED'S EDUCATION

138. DECEASED'S RELIGION

139. DECEASED'S SERVICE

140. DECEASED'S DATE OF DEATH

141. DECEASED'S TIME OF DEATH

142. DECEASED'S PLACE OF DEATH

143. DECEASED'S CAUSE OF DEATH

144. DECEASED'S MANNER OF DEATH

145. DECEASED'S SIGNATURE

146. DECEASED'S ADDRESS

147. DECEASED'S CITY

148. DECEASED'S COUNTY

149. DECEASED'S STATE

150. DECEASED'S ZIP CODE

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216. DECEASED'S MANNER OF DEATH

217. DECEASED'S SIGNATURE

218. DECEASED'S ADDRESS

219. DECEASED'S CITY

220. DECEASED'S COUNTY

221. DECEASED'S STATE

222. DECEASED'S ZIP CODE

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224. DECEASED'S SOCIAL SECURITY NUMBER

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226. DECEASED'S OCCUPATION

227. DECEASED'S EDUCATION

228. DECEASED'S RELIGION

229. DECEASED'S SERVICE

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232. DECEASED'S PLACE OF DEATH

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234. DECEASED'S MANNER OF DEATH

235. DECEASED'S SIGNATURE

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245. DECEASED'S EDUCATION

246. DECEASED'S RELIGION

247. DECEASED'S SERVICE

248. DECEASED'S DATE OF DEATH

249. DECEASED'S TIME OF DEATH

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01231

1286 CERTIFICATE OF DEATH

Reg. Dist. No. **9**

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>Rt. 2, Frostburg,</u>		<u>Lifetime</u>		<u>Rt. 2, Frostburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Michael</u> (Middle) <u>Vincent</u> (Last) <u>Larkin</u>				Feb. 6th, 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>May 25th, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret.-Self Employed</u>		<u>Carpenter</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Peter Larkin</u>				<u>Mary Ann Farrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		Rt. 2, Frostburg,	
<u>Yes</u> <u>W. W. 1</u>		<u>None</u>		<u>Mrs. Michael V. Larkin,</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>Sudden</u>			
				<u>Several years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>Feb 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>56</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. W. Lane MD</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg Md</u> DATE SIGNED <u>Feb 8 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 9th, 56</u>		<u>St. Patrick's Cemetery</u>		<u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2-8-56</u>		<u>Wm. Harvey A. Roe</u>		<u>Joseph R. Durst, Frostburg, Md.</u>			

DEATH CERTIFICATE

DEPARTMENT OF HEALTH - BALTIMORE 10

67831

1. PLACE IN WHICH DECEASED WAS FOUND

2. CAUSE OF DEATH (State immediately and briefly)

3. MANNER OF DEATH (State immediately and briefly)

4. PLACE OF DEATH (State immediately and briefly)

5. DATE OF DEATH (State immediately and briefly)

6. TIME OF DEATH (State immediately and briefly)

7. NAME OF DECEASED (State immediately and briefly)

8. SEX OF DECEASED (State immediately and briefly)

9. AGE OF DECEASED (State immediately and briefly)

10. OCCUPATION OF DECEASED (State immediately and briefly)

11. MARITAL STATUS OF DECEASED (State immediately and briefly)

12. EDUCATION OF DECEASED (State immediately and briefly)

13. RELIGION OF DECEASED (State immediately and briefly)

14. PLACE OF BIRTH OF DECEASED (State immediately and briefly)

15. DATE OF BIRTH OF DECEASED (State immediately and briefly)

16. TIME OF BIRTH OF DECEASED (State immediately and briefly)

17. NAME OF FATHER OF DECEASED (State immediately and briefly)

18. NAME OF MOTHER OF DECEASED (State immediately and briefly)

19. NAME OF SPOUSE OF DECEASED (State immediately and briefly)

20. NAME OF CHILDREN OF DECEASED (State immediately and briefly)

21. NAME OF SIBLINGS OF DECEASED (State immediately and briefly)

22. NAME OF OTHER RELATIVES OF DECEASED (State immediately and briefly)

23. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S DEED (State immediately and briefly)

24. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S WILL (State immediately and briefly)

25. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S ESTATE (State immediately and briefly)

26. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S PROPERTY (State immediately and briefly)

27. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S ASSETS (State immediately and briefly)

28. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S LIABILITIES (State immediately and briefly)

29. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S DEBTS (State immediately and briefly)

30. NAME OF PERSONS WHOSE NAMES ARE ON DECEASED'S OBLIGATIONS (State immediately and briefly)

REMARKS

REMARKS (State immediately and briefly)

BUREAU V. 1

FEB 10 1956

RECEIVED

JOHN A. MURPHY, PROSECUTOR

JOHN A. MURPHY, PROSECUTOR

JOHN A. MURPHY, PROSECUTOR

JOHN A. MURPHY, PROSECUTOR

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1273				01232			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN <u>Frostburg</u>				TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Miners Hospital.</u>				STREET ADDRESS (If rural, give location) <u>7 Baptist St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)			
(Type or Print) <u>Joseph Edward Lavin</u>		<u>Feb. 4</u>		<u>19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>Married</u>	<u>May 30-1896</u>	<u>59</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Truck Driver</u>		<u>C&P.R.Ry.</u>		<u>Hoffman, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Michael Lavin</u>				<u>Rose Folk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>Yes</u>		<u>W. War I</u>		<u>(wife) Lavern Lavin, Frostburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary sclerosis</u> DUE TO (Sudden death)							
Antecedent cause(s) (b) <u>Arteriosclerosis</u> DUE TO						?	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Cardiac hypertrophy</u>						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Barbiturates 1.3%</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>Feb. 4-1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-7-56</u>		<u>St. Michael's Cemetery</u>		<u>Frostburg Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>2-7-56</u>		<u>Mr. Nancy A. Roe</u>		<u>Burial H. Montross</u>		<u>23 E. Main Frostburg, Md.</u>	

BUREAU V. 3

FEB 10 1955

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01233

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>		
c. LENGTH OF STAY IN 1b <u>4 Months</u>			d. STREET ADDRESS <u>27 Ridgeway Terrace</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>27 Ridgeway Terrace</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence</u> <u>Richard</u> <u>Leasure</u>			4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>29</u> <u>19 56</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April-7-1926</u>		9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer & Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>work in army</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Clarence Leasure</u>			14. MOTHER'S MAIDEN NAME <u>Helen Marie Wolfe</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			16. SOCIAL SECURITY NO. <u>W.W. 2 220-16-5898</u>		
17. INFORMANT <u>(Mother)</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Destruction of skull (upper & posterior part) sudden</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and brain. (Entrance-middle of forehead.)</u> (c) <u>Rifle Winchester 30-30 caliber bullet, self inflicted.</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Placed rifle stock on floor & between knees, muzzle to forehead.</u>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Despondent.</u>			20b. TIME OF INJURY Month, Day, Year <u>about 3.30-2-27-56</u>		
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		
20e. (City or town) <u>Cumberland</u>			20f. (County) <u>Allegany</u>		
20g. (State) <u>Md.</u>			21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Feb. 29-1956</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cumberland, Maryland.</u>		22e. (State) <u>Md.</u>		22f. REC'D BY REGISTRAR <u>March 1, 1956</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>		23b. ADDRESS		24b. REGISTRAR'S SIGNATURE <u>M.R. [Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH
STATE OF OHIO - COLUMBUS

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
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46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
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58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
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64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
MAR 5 1956
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01234

1287 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Rt. # 3 Cumberland,</u>				TOWN <u>Rt. # 3 Cumberland,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Hazen Road</u>				<u>Hazen Road</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>IRA</u>		<u>BLISS</u>		<u>LEASURE</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept. 19, 1880</u>	
9. AGE last birthday: <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Hazen, Maryland</u>		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired tire builder</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Kelly Tire Co.</u>		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Harvey Leasure</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Hardinger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No,</u>		16. SOCIAL SECURITY NO. <u>217-10-6473</u>		17. INFORMANT & ADDRESS: <u>Mrs. H. D. Hart Rt #3 Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>				<u>about 20 yrs</u>			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>✓</u>							
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION <u>✓</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <u>✓</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>12/14, 1955</u> , to <u>2/10, 1956</u> that I last saw the deceased alive on <u>2/10/56</u> , 19 <u>56</u> , and that death occurred at <u>7:40AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hardison R. Hart</u>		M. D. <u>48 Broadway Brooklyn - 2/10/56</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 11, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hart, M.D.</u>		24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	

BUREAU V. S.

FEB 15 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01235

1288 **CERTIFICATE OF DEATH**Reg. Dist. No. 2

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Flintstone</u>		<u>Yrs</u>		TOWN <u>Flintstone</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 [REDACTED], Flintstone</u>				STREET ADDRESS (If rural give location) <u>[REDACTED], Flintstone</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EUNICE</u> (Middle) <u>MATILDA</u> (Last) <u>LITTLEFIELD</u>				(Month) <u>February</u> (Day) <u>17</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>March 1, 1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Wn Home</u>		<u>Bedford County, Penn.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William H. Browning</u>				<u>Cornelia Brotemarkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Rt. 2 Lewis. L. Littlefield, Flintstone</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.0</u>				<u>chronic cardiac decompensation</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>arteriosclerotic heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>marasmus</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> el work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 19, 1956</u> to <u>Feb. 19, 1956</u> , that I last saw the deceased alive on <u>Feb. 19, 1956</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Annabell Brings</u>				ADDRESS (Street, city, town, state) <u>55 Greene St. Cumberland</u>		DATE SIGNED <u>4/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 19, 1956</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb 19, 1956</u>		<u>Thia L. Bender</u>		<u>John J. Hafer</u>		<u>Cumberland, Maryland</u>	

CERTIFICATE OF DEATH

REG. NO.

DEATH NUMBER (NUMBER OF DECEASED)

NAME	AGE	SEX	RACE
DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH
CAUSE OF DEATH	IMMEDIATE CAUSE	INTERMEDIATE CAUSE	FINAL CAUSE

Handwritten notes in the center of the form, possibly indicating a specific medical condition or cause of death.

Handwritten signature or name at the bottom center of the form.

BUREAU V. 1

FEB 23 1956

RECEIVED

Vertical text on the right margin, likely a filing or processing stamp, partially obscured by a large black mark.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1289				01236			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No. 9			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Eckhart</u>		<u>80 yrs.</u>		TOWN <u>1-R.F.D. #2 Frostburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway -Route 40</u>				STREET ADDRESS (If rural, give location) <u>(Eckhart, Md.)</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>James</u>		(Middle) <u>Edward</u>		(Last) <u>Logsdon</u>		(Month) (Day) (Year) <u>Feb. 26 19 56</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>		8. DATE OF BIRTH: <u>May 20-1875</u>	
9. AGE last birthday: <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Storeman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B&O.R.Ry.</u>		11. BIRTHPLACE (State or foreign country): <u>Frostburg Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Samuel Logsdon</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Lewis.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u>705-05-5607</u>		17. INFORMANT & ADDRESS: <u>Md. (daughter) Mrs. Clair Catherman, Eckhart</u>					
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
(a) Immediate cause <u>Shock, exsanguination, multiple fractures of</u>				<u>sudden</u>			
DUE TO							
(b) Antecedent cause(s) <u>neck, left humerous, left leg at knee, right</u>							
DUE TO							
(c) <u>leg above ankle, pelvis, right leg nearly torn off at</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>hip also lacerations.</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>12-05</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Route 40</u>		21c. (City or town) (County) (State) <u>Eckhart Allegany Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb. 26/56 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Walking across Rt. 40 hit by a car going west.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE							
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		M. D.		DATE SIGNED <u>Feb. 26/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>		FUNERAL DIRECTOR <u>Bulah H. Montesau</u>		ADDRESS <u>23 E. Main Frostburg, Md.</u>	
Haier Funeral Home							

BUREAU V. 3

FEB 29 1956

RECEIVED

1553

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

REG. DIST. NO.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF COURT

22. SIGNATURE OF STATE

23. SIGNATURE OF UNION

24. SIGNATURE OF COUNTRY

25. SIGNATURE OF WORLD

26. SIGNATURE OF UNIVERSE

27. SIGNATURE OF GOD

28. SIGNATURE OF DEVIL

29. SIGNATURE OF ANGELS

30. SIGNATURE OF DEMONS

31. SIGNATURE OF SPIRITS

32. SIGNATURE OF GHOSTS

33. SIGNATURE OF PHANTOMS

34. SIGNATURE OF Wraiths

35. SIGNATURE OF Shades

36. SIGNATURE OF Souls

37. SIGNATURE OF Spirits

38. SIGNATURE OF Ghosts

39. SIGNATURE OF Wraiths

40. SIGNATURE OF Shades

41. SIGNATURE OF Souls

42. SIGNATURE OF Spirits

43. SIGNATURE OF Ghosts

44. SIGNATURE OF Wraiths

45. SIGNATURE OF Shades

46. SIGNATURE OF Souls

47. SIGNATURE OF Spirits

48. SIGNATURE OF Ghosts

49. SIGNATURE OF Wraiths

50. SIGNATURE OF Shades

51. SIGNATURE OF Souls

52. SIGNATURE OF Spirits

53. SIGNATURE OF Ghosts

54. SIGNATURE OF Wraiths

55. SIGNATURE OF Shades

56. SIGNATURE OF Souls

57. SIGNATURE OF Spirits

58. SIGNATURE OF Ghosts

59. SIGNATURE OF Wraiths

60. SIGNATURE OF Shades

61. SIGNATURE OF Souls

62. SIGNATURE OF Spirits

63. SIGNATURE OF Ghosts

64. SIGNATURE OF Wraiths

65. SIGNATURE OF Shades

66. SIGNATURE OF Souls

67. SIGNATURE OF Spirits

68. SIGNATURE OF Ghosts

69. SIGNATURE OF Wraiths

70. SIGNATURE OF Shades

71. SIGNATURE OF Souls

72. SIGNATURE OF Spirits

73. SIGNATURE OF Ghosts

74. SIGNATURE OF Wraiths

75. SIGNATURE OF Shades

76. SIGNATURE OF Souls

77. SIGNATURE OF Spirits

78. SIGNATURE OF Ghosts

79. SIGNATURE OF Wraiths

80. SIGNATURE OF Shades

81. SIGNATURE OF Souls

82. SIGNATURE OF Spirits

83. SIGNATURE OF Ghosts

84. SIGNATURE OF Wraiths

85. SIGNATURE OF Shades

86. SIGNATURE OF Souls

87. SIGNATURE OF Spirits

88. SIGNATURE OF Ghosts

89. SIGNATURE OF Wraiths

90. SIGNATURE OF Shades

91. SIGNATURE OF Souls

92. SIGNATURE OF Spirits

93. SIGNATURE OF Ghosts

94. SIGNATURE OF Wraiths

95. SIGNATURE OF Shades

96. SIGNATURE OF Souls

97. SIGNATURE OF Spirits

98. SIGNATURE OF Ghosts

99. SIGNATURE OF Wraiths

100. SIGNATURE OF Shades

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>5 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>232 N.Center St.</u>				STREET ADDRESS (If rural, give location) <u>232 N.Center St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>John</u> <u>Joseph</u> <u>McPartland</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>19</u> <u>19 56</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Feb.21-1892</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life) <u>Pipefitter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Cellanese Corp.of Am.</u>		11. BIRTHPLACE (State or foreign country): <u>Westernport,Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John J. Mc Partland</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Halfpenny</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>✓</u> <u>W.W.1</u>		16. SOCIAL SECURITY No.: <u>214-07-5443</u>		17. INFORMANT & ADDRESS: <u>(wife) Loretta McPartland, Cumberland Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES AND CONDITIONS DIRECTLY LEADING TO DEATH:		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Coronary sclerosis. Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				sudden ?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		H. V. Deming M.D. H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> Feb. 20-1956	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 22, 1956		St. Peter and Paul Cem. Cumberland, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
Feb. 21, 1956		Walter K. Trantz, M.D.		James F. Scarpelli, " "	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. 81

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1-291

CERTIFICATE OF DEATH

01239

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Midland</u>		<u>75 yrs</u>		TOWN <u>Midland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Julia</u> <u>McVeigh</u>				<u>Feb 23</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>July 10, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>House Work</u>			<u>Own Home</u>		<u>Moscow, Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Hugh McVeigh</u>				<u>Catherine Cavanaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Mrs. Robert Ward</u> <u>Midland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>				<u>Noice</u>		<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>						<u>Several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 22, 1956</u>, to <u>Feb 23, 1956</u>, that I last saw the deceased alive on <u>Feb 22, 1956</u>, and that death occurred at <u>4:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Wm. Lane</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Eastburg Md</u>		<u>2-24-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>Feb 27/56</u>	<u>Belvedere Cemetery</u>	<u>Midland,</u>		<u>M d.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-27-56</u>		<u>Juanette M Boal</u>		<u>George Eichhorn</u>		<u>Lenacoring, Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-55

1. DEATH OCCURRED (Month of Occurrence)

2. DEATH OCCURRED (Day of Occurrence)

3. DEATH OCCURRED (Year of Occurrence)

4. DEATH OCCURRED (Time of Occurrence)

5. DEATH OCCURRED (Place of Occurrence)

6. DEATH OCCURRED (Cause of Death)

7. DEATH OCCURRED (Manner of Death)

8. DEATH OCCURRED (Age at Death)

9. DEATH OCCURRED (Sex of Deceased)

10. DEATH OCCURRED (Race of Deceased)

11. DEATH OCCURRED (Occupation of Deceased)

12. DEATH OCCURRED (Education of Deceased)

13. DEATH OCCURRED (Marital Status of Deceased)

14. DEATH OCCURRED (Previous Illnesses)

15. DEATH OCCURRED (Previous Injuries)

16. DEATH OCCURRED (Previous Operations)

17. DEATH OCCURRED (Previous Hospitalizations)

18. DEATH OCCURRED (Previous Deaths)

19. DEATH OCCURRED (Previous Accidents)

20. DEATH OCCURRED (Previous Suicide Attempts)

21. DEATH OCCURRED (Previous Mental Illnesses)

22. DEATH OCCURRED (Previous Substance Abuse)

23. DEATH OCCURRED (Previous Alcohol Consumption)

24. DEATH OCCURRED (Previous Drug Use)

25. DEATH OCCURRED (Previous Tobacco Use)

BUREAU V. S.

MAR 5 1956

RECEIVED

NOTIFICATION

1. This certificate is to be used for the purpose of notifying the family of the death of a person who has died in the State of Maryland. It is to be filled out by the attending physician or the coroner, and it is to be signed by the physician or coroner. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be used for the purpose of notifying the family of the death of a person who has died in the State of Maryland. It is to be filled out by the attending physician or the coroner, and it is to be signed by the physician or coroner. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be used for the purpose of notifying the family of the death of a person who has died in the State of Maryland. It is to be filled out by the attending physician or the coroner, and it is to be signed by the physician or coroner. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1292 **CERTIFICATE OF DEATH**

01240

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Black Oak</u>		<u>38 yrs</u>		TOWN <u>Black Oak</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD # 3, Keyser, W. Va.</u>				STREET ADDRESS (If rural give location) <u>RFD # 3, Keyser, W. Va.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Minnie</u> (Middle) <u>Anderson</u> (Last) <u>Miller</u>				(Month) <u>Feb</u> (Day) <u>4</u> (Year) <u>19 56</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>17 April 1884</u>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>71 yrs.</u>		<u>Domestic</u>		<u>Own home</u>		<u>Deer Run, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>US</u>				<u>Milton Heavner</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Catherine Jerdin</u>				<u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>none</u>				<u>RFD #3 Keyser, W. Va.</u>			
<u>Robert L. Miller, Black Oak</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Cerebral Anoxia</u>						<u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lactory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1956</u>, to <u>Feb 4</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan 1956</u>, and that death occurred at <u>M</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Robert L. Miller</u>				<u>7/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7 Feb 56</u>		<u>Miller Cemetery</u>		<u>Black Oak, Allegany, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2-7-56</u>		<u>Mr. Jean C Kelly</u>		<u>E. J. B. B. - Westinghouse, Md.</u>			

BUREAU V. S.

FEB 9 1966

RECEIVED

1244

01241

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Cumberland</u>		<u>38</u> days		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>Jane Frazier Village, Apt. K 3</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>Charles E. Millerson</u>				<u>Feb. 24 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>married</u>	<u>Sept. 7-1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer</u>		<u>Kelley S. Tire Co.</u>		<u>Hampshire Co. W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Millerson</u>				<u>Sarah Moreland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>314-07-0127</u>		<u>Memorial Hospital records.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
(a) <u>Myocardial failure</u>				<u>Gradual</u>	
Immediate cause DUE TO					
(b) <u>Senility & arteriosclerosis also had</u>				<u>?</u>	
Antecedent cause(s) DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last					
(c) <u>Fracture of left femur at surgical neck</u>				<u>38 days</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
<u>Jan. 19-1956</u>		<u>Fracture of left femur, Jewitt pin inserted.</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. (City or town) (County) (State)	
<u>CAUSE OF DEATH</u>		<u>City Hall</u>		<u>Cumberland Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<u>Jan. 18/56 P.M.</u>				<u>Son had an epileptic seizure while walking down steps, fell against his father knocking him down.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H. V. Deming M.D.</u>		<u>H. V. Deming M.D.</u>		<u>Feb. 24-1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Feb. 27, 1956</u>		<u>Stonesville Cemetery</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Feb. 27, 1956</u>		<u>Walter R. Tandy M.D.</u>		<u>H. Lee Riley, Cumberland, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 23 1961

RECEIVED

1245

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		9/22/53		TOWN Cumberland		02	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS Glenn Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Amanda		(Middle)		(Last) Myers		(Day) 25, (Year) 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widow	9/7/1861	94 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Ohio		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Francis Barker				Rachael Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Allegany County Infirmary Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
592x IMMEDIATE CAUSE (A) Chronic Myocarditis							
ANTECEDENT CAUSE(S) DUE TO Cerebral Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO Chronic Hepatitis							
STATING UNDERLYING CAUSE LAST, (C) Severe Deterioration							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 2, 1955, to Feb 25, 1956, that I last saw the deceased alive on Feb 25, 1956, and that death occurred at 11:38 P.M. from the causes and on the date stated above.							
SIGNATURE James E. McLean				ADDRESS (Street, city, town, state) 49 Greene St.		DATE SIGNED 2-27-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 28, 1956		Cross Cemetery		Cross, Mineral County, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
Feb. 28, 1956		Winter R. Frantz, M.D.		Boal's Funeral Home, Westernport, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

State of Maryland
 County of Baltimore
 City of Baltimore
 Name of Deceased
 Date of Death
 Place of Death

Age at Death
 Sex
 Race
 Marital Status
 Occupation

Cause of Death
 Immediate Cause
 Underlying Cause

Signature of Physician
 Signature of Registrar

BUREAU V. S.

MAR 1 1956

RECEIVED

1246

CERTIFICATE OF DEATH

DR. ■ JACOBSON

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		9 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
MEMORIAL HOSPITAL				237 HENDERSON AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) OSCAR (Middle) E. (Last) NORRIS				(Month) FEBRUARY (Day) 25 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	DIVORCED	FEBRUARY 24, 1999	57 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Carpenter		B & O RR		MARYLAND Cumberland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY NORRIS				ANNA ZIMMERMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
yes				214-05-7703		MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
584X IMMEDIATE CAUSE (A) Acute Dilatation of Heart						10 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Obstructive jaundice						14 days ?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cholesystitis						14 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic glomerular nephritis						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-16-56, 1956, to 2-25-56, 1956, that I last saw the deceased alive on Feb. 25, 1956, and that death occurred at 10:45 P.M. from the causes end on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
DATE THEREOF				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial		Hillcrest Burial Park		Cumberland, Maryland			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 29. 1956		Winter R. Frantz, M.D.		John J. Hafer, Cumberland, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1946 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FILE NO.

DR. J. J. JACOBSON

ALLIED AMERICAN

MARYLAND

DEATH

ALLIED AMERICAN

CINCINNATI

2 DAYS

DE BELAND

331 HENDERSON AVENUE

CHICAGO HOSPITAL

CHICAGO HOSPITAL

CHICAGO

CHICAGO

1

FEBRUARY 2, 1946

DIVORCED

WHITE

MALE

MARYLAND

CHICAGO HOSPITAL

CHICAGO HOSPITAL

CHICAGO HOSPITAL - CHICAGO, ILL.

IN MEDICAL EXAMINATION

CHICAGO HOSPITAL

BUREAU V. 3

MAR 2 1956

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1247 CERTIFICATE OF DEATH

01244

DR. VAN ORMER

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE W.VA.		COUNTY HARDY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN CUMBERLAND		8 DAYS		TOWN MOOREFIELD		85 x - 3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
MARY E. POLING				FEBRUARY 4 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED	AUGUST 23, 1884	71 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		WEST VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
M FRANK SIMMONS				MC DOWELL, ANGELINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 week	
592X IMMEDIATE CAUSE (A) Hemia							
ANTECEDENT CAUSE(S) DUE TO Arteriosclerotic Heart Disease with congestive failure.						10 days.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Chronic nephritis						?	
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes mellitus						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 26 Jan., 1956, to 4 Feb., 1956, that I last saw the deceased alive on 3 Feb., 1956, and that death occurred at 5:55 AM, from the causes and on the date stated above.							
SIGNATURE W. Alfred Van Ormer				ADDRESS (Street, city, town, state) Cumberland, Md.		DATE SIGNED 4 Feb. 56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 7 - 1956		Olivet Cemetery		Moorefield, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Feb. 6, 1956		Walter R. Frantz, M.D.		P.E. Shush & Son		Moorefield, W. Va.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

FILE NO. 100

DATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX

3. AGE

4. RACE

5. PLACE OF BIRTH (PRINT OR TYPE)

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF INTERMENT

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. DATE OF DEATH

15. TIME OF DEATH

16. PLACE OF DEATH

17. SEX

18. RACE

19. AGE

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. PLACE OF DEATH

23. CAUSE OF DEATH

24. MANNER OF DEATH

25. PLACE OF INTERMENT

BUREAU V. 3

FEB 7 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1248

CERTIFICATE OF DEATH

01245

Reg. Dist. No. 4

Within corporate limits

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND COUNTY ALLEGANY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN CUMBERLAND		LENGTH OF STAY (In this place) 6 DAYS		CITY OR TOWN CUMBERLAND		CITY OR TOWN CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 1201 MICHIGAN AVENUE			
3. NAME OF DECEASED (First) VERNA (Middle) V (Last) POMEROY				4. DATE OF DEATH (Month) FEB. (Day) 7 (Year) 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 8-8-1904	9. AGE last birthday 52 yrs.	IF UNDER 1 YEAR (Months) (Days)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD. Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME YEAGY, JOHN H.				14. MOTHER'S MAIDEN NAME BEACHLEY, VICTORIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				9 days			
0570 IMMEDIATE CAUSE (A) Meningitis, Cerebro Spinal							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 36, to Feb 6 19 56, that I last saw the deceased alive on Feb 6 19 56, and that death occurred at 3:45 A.M. from the causes and on the date stated above.							
SIGNATURE <i>James F. Scarpelli</i>				ADDRESS (Street, city, town, state) 133 Va. Ave. Cum B. Md.		DATE SIGNED 2/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-10-56		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>W. R. D. Kautz, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Scarpelli</i>		ADDRESS	
DATE Feb. 10, 1956							

CERTIFICATE OF DEATH

NAME OF DECEASED YENGY, JOHN H.		SEX MALE		RACE WHITE		DATE OF BIRTH JAN 15 1901		PLACE OF BIRTH ALLEGANY, W. VA.	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED	
EDUCATION		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		FARMER		FARMER		FARMER		FARMER	
RESIDENCE		1501 NICHIGAN AVE		1501 NICHIGAN AVE		1501 NICHIGAN AVE		1501 NICHIGAN AVE	
DATE OF DEATH		FEB 14 1956		FEB 14 1956		FEB 14 1956		FEB 14 1956	
PLACE OF DEATH		HOSPITAL		HOSPITAL		HOSPITAL		HOSPITAL	
CAUSE OF DEATH		MURDER		MURDER		MURDER		MURDER	
MANNER OF DEATH		HOMICIDE		HOMICIDE		HOMICIDE		HOMICIDE	
REPORTED BY		POLICE		POLICE		POLICE		POLICE	
SIGNATURE		J. H. YENGY		J. H. YENGY		J. H. YENGY		J. H. YENGY	
DATE		FEB 14 1956		FEB 14 1956		FEB 14 1956		FEB 14 1956	

2 gandy

Murdering, Governor Jones

BUREAU V. X

FEB 14 1956

RECEIVED

John H. Yengy

INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01246

1274 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>FROSTBURG</u>		<u>7 DAYS</u>		TOWN <u>Mt. SAVAGE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALEXANDER RANKIN</u>				<u>Feb 7 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JULY 25, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>CAR REPAIRMAN</u>		<u>C+P RAILROAD</u>		<u>ZIHLMAN, MD</u>		<u>USA</u>	
13. FATHER'S NAME <u>ANDREW RANKIN</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>244-32-3423</u>		17. INFORMANT & ADDRESS <u>Mrs. Bessie RANKIN</u> <u>Mt. SAVAGE MD</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>3 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE HEART DISEASE</u>						<u>4 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>7 days</u>	
18. MEDICAL CERTIFICATION <u>BRONCHOPNEUMONIA & UREMIA</u>							
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>✓</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>✓</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>1/28</u>, 19<u>56</u>, to <u>2/7</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/7</u>, 19<u>56</u>, and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Madeline M. Stetson</u>		M.D. <u>45 Broadway - Frostburg Md</u>		DATE SIGNED <u>2/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Feb. 10 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cooks Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wellersburg PA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Miss Nancy N. DeHarvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leigler, Hyndman Pa</u>		ADDRESS	
DATE <u>2-8-56</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01247

1249

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY <u>Cumberland</u>		CITY <u>Cumberland</u>	
CITY <u>Cumberland</u>		LENGTH OF STAY <u>30 Yrs</u>		TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12 Boone St.</u>				STREET ADDRESS <u>12 Boone St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Carrie E Rice</u>				<u>Feb. 9 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1/27/1877</u>	
9. AGE last birthday <u>79</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.R. England</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Ridgeway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS <u>Mrs Ruth Wolford Cumberland, Md.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>(Dead on Arrival)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.							
SIGNATURE <u>Clay E. Linn</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland - 7/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Queens Point Cemetery</u>		LOCATION (City, town, or county) (State) <u>Keyser West Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Keady MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	
DATE <u>Feb 10, 1956</u>							

INSTRUCTIONS

1 **1** **1**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

DR DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01248

1250 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		4 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 448 WILLIAMS STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
LUCRETIA G RITCHIE				2- 1 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED	FEBRUARY 23, 1882	73 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Housewife)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) PAW PAW, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK K DUNN				14. MOTHER'S MAIDEN NAME MARTHA SHORT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Memorial Hospital			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Myocarditis & Decompensation						INTERVAL BETWEEN ONSET AND DEATH 18 min	
ANTECEDENT CAUSE(S) DUE TO (B) Cardiac Asthma						3 min	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 15, 19 56</u>, to <u>Feb 1, 19 56</u> that I last saw the deceased alive on <u>Feb 1, 19 56</u> and that death occurred at <u>7:40</u> A.M. from the causes and on the date stated above.							
SIGNATURE <i>Clayton Durrett</i>		ADDRESS (Street, city, town, state) <i>Cumberland</i>		DATE SIGNED <i>2/2/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 3, 1956		NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. REC'D BY REGISTRAR Feb. 2, 1956		REGISTRAR'S SIGNATURE <i>Walter R. Frank, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland			

1930 CERTIFICATE OF DEATH

MANITOWA STATE DEPARTMENT OF HEALTH - BRITAIN, 1930

630-100-10

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. DECEASED'S SEX AND AGE AT DEATH

3. DECEASED'S OCCUPATION

4. DECEASED'S MARITAL STATUS

5. DECEASED'S PLACE OF BIRTH

6. DECEASED'S DATE OF BIRTH

7. DECEASED'S PLACE OF DEATH

8. DECEASED'S DATE OF DEATH

9. DECEASED'S TIME OF DEATH

10. DECEASED'S CAUSE OF DEATH

11. DECEASED'S MANNER OF DEATH

12. DECEASED'S SIGNATURE

13. DECEASED'S ADDRESS

14. DECEASED'S CITY

15. DECEASED'S COUNTY

16. DECEASED'S STATE

17. DECEASED'S COUNTRY

18. DECEASED'S RACE

19. DECEASED'S RELIGION

20. DECEASED'S EDUCATION

21. DECEASED'S HEIGHT

22. DECEASED'S WEIGHT

23. DECEASED'S TEMPERATURE

24. DECEASED'S PULSE

25. DECEASED'S RESPIRATION

26. DECEASED'S BLOOD PRESSURE

27. DECEASED'S URINE

28. DECEASED'S STOOL

29. DECEASED'S SWEAT

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37. DECEASED'S PROTONS

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48. DECEASED'S PRESSURES

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50. DECEASED'S MASSES

51. DECEASED'S CHARGES

52. DECEASED'S MOMENTS

53. DECEASED'S PRODUCTS

54. DECEASED'S SUMS

55. DECEASED'S DIFFERENCES

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57. DECEASED'S PROPORTIONS

58. DECEASED'S PERCENTAGES

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01249

1293 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural Oldtown</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oldtown</u>			
TOWN <u>Rural Oldtown</u>				STREET ADDRESS (If rural give location) <u>Paw Paw, W Va</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 1, Paw Paw, W Va</u>							
3. NAME OF DECEASED (Type or Print) <u>CARRIE M. Robertson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 24, 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 17, 1884</u>	
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES Reckley</u>				14. MOTHER'S MAIDEN NAME <u>Emily Jane Robey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Route 1, O.H. Robertson, Paw Paw, W Va</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Neurovascular Central</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
ANTECEDENT CAUSE(S) <u>Due to</u>				<u>andary Carcinoma rectum</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>1-2 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma rectum</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-23-56</u> to <u>2-24-56</u>, that I last saw the deceased alive on <u>2-23-56</u>, and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Armstrong</u>		M.D. <u>Paw Paw W. Va</u>		ADDRESS (Street, city, town, state) <u>2-24-56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/26/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Iders Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md</u>	
24. REC'D BY REGISTRAR <u>Feb 26, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Ray Duckworth</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Right</u>		ADDRESS <u>Cumberland, Md.</u>	

288

(Faint handwritten notes at the bottom of the page)

1890

BUREAU V. S.

MAR 2 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01250

1251

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN IB 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS (Rural)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GRANVILLE Middle W. Last RUCKMAN				4. DATE OF DEATH Month 2 Day 28 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-1900	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ARTHUR RUCKMAN				14. MOTHER'S MAIDEN NAME KEISTER, EMMA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Hypertrophy DUE TO (c) Cardiac Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22-1956 to 2-28-1956 ; that I last saw the deceased alive on 2-27-1956 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1728. Centre St. Cumberland Md. DATE SIGNED Feb.							
ACTUAL SIGNATURE W.F. Williams M.D.				PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 1 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) (Near) Augusta, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs ADDRESS Romney, W. Va.				24a. REC'D BY REGISTRAR March 1, 1956		24b. REGISTRAR'S SIGNATURE W.R. Brant, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

MAR 5 1955

RECEIVED

1 Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1252 CERTIFICATE OF DEATH

01251

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH COUNTY <u>ALLEGANY</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>PENNA</u> COUNTY <u>Bedford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HYNDMAN</u> STREET ADDRESS (If rural give location) <u>75x3</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>CLARA (HYRE) SCRITCHFIELD</u> (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 9, 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Nov. 30, 1881</u>
9. AGE last birthday <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>
11. BIRTHPLACE (State or foreign country) <u>MOOREFIELD, W.VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY RIGGLEMAN</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA SIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>RAY HYRE, HYNDMAN, PA</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 18. MEDICAL CERTIFICATION 151X IMMEDIATE CAUSE (A) <u>CARCINOMA Stomach</u> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, lecture, of injury street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Feb. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 6</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>John L. Topper</u>		DATE SIGNED <u>2/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>	
DATE THEREOF <u>Feb 12, 1956</u>		LOCATION (City, town, or county) (State) <u>Hyndman, Pa Bt Bedford</u>	
25. REC'D BY REGISTRAR <u>Feb. 11, 1956</u>		26. REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>	
27. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler</u>		ADDRESS <u>Hyndman, Pa.</u>	

CERTIFICATE OF DEATH

REG. GEN. 114

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. NAME OF PHYSICIAN

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

BUREAU V. 2

FEB 15 1956

RECEIVED

REC'D 1201201201

RECEIVED
FEB 15 1956
BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01252

Within corporate limits

1253

CERTIFICATE OF DEATH

Reg. Dist. No. *K*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>3 days</u>		TOWN <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>12 N. MECHANIC</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EVA</u> (Middle) <u>SHAFFER</u> (Last)				(Month) <u>2</u> (Day) <u>8</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-24-1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Confluence</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>STEPHEN McCLINTOCK</u>				14. MOTHER'S MAIDEN NAME <u>LAURA Kensinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>722 Fayette St., Cumb. Md.</u>			
				<u>OLD CLARK Mrs. George Leib</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
491x IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							<u>3 days</u>
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/5</u> , 19 <u>56</u> , to <u>2/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/8</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>B. W. Truskis, Jr.</u>				ADDRESS (Street, city, town, state) <u>Cumberland Maryland</u>		DATE SIGNED <u>2/19/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Walter R. Hunt, MD.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
DATE <u>Feb. 19, 1956</u>				GEORGE FUNERAL HOME			

1275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart Mines</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>Box 34</u>	
3. NAME OF DECEASED (Type or print) <u>Susan</u> First <u>J.</u> Middle <u>Skelly</u> Last		4. DATE OF DEATH <u>2</u> Month <u>23</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 / 27 / 1868</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Miller</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Box 34</u> Address <u>Cleveland Shimer Eckhart Mines, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) <u>senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 23, 1956</u> , to <u>Feb 23, 1956</u> , that I last saw the deceased alive on <u>Feb 23, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W O Mc Lane</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg Md</u> DATE SIGNED <u>2-25-56</u>	
PHYSICIAN'S NAME (Type) <u>W O Mc Lane MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Catholic</u>	22d. LOCATION (City, town, or county) (State) <u>Cresaptown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Winters</u>		24a. REC'D BY REGISTRAR <u>DATE 2-27-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm Henry N. Roe</u>			

Hafer Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician must sign the certificate. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director.

1254

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 615 Piedmont Ave.				d. STREET ADDRESS 615 Piedmont Ave.			
3. NAME OF DECEASED (Type or print) First Nora Middle Blanche Last Snyder				4. DATE OF DEATH Month Feb. Day 29 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1872		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Bedford Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel W. Snyder				14. MOTHER'S MAIDEN NAME Catherine Boore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Grover C. Snyder Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 6 hr 6 yr 6 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. , 1950, to 2/29 , 1956, that I last saw the deceased alive on 2/29 , 1956, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE George M. Simons M.D. 1284 Union St, Cumberland, Md. PHYSICIAN'S NAME (Type) George M. Simons, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 2, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Frantz, M.D.			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		45		M		W		1911		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1935		BALTIMORE, MD.		JAMES M. JONES		1965		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1965		BALTIMORE, MD.		BALTIMORE, MD.		1965		BALTIMORE, MD.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1965		BALTIMORE, MD.		DR. J. M. JONES		1965		BALTIMORE, MD.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1965		BALTIMORE, MD.		DR. J. M. JONES		1965		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
J. M. JONES		1965		BALTIMORE, MD.		DR. J. M. JONES		1965		BALTIMORE, MD.	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
J. M. JONES		1965		BALTIMORE, MD.		DR. J. M. JONES		1965		BALTIMORE, MD.	

BUREAU V. S.

MAR 5 1956

RECEIVED

1255

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Cumberland,</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Cumberland,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>408 N. Centre St.,</u>				STREET ADDRESS (If rural give location) <u>408 N. Centre St.,</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MICHAEL LEONARD STEGMAIER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 6, 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 11, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Merchant Grocery</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME: <u>Leonard Stegmaier</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Hook</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No,</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Cumberland, Md.</u> <u>Mrs. Margaret Stegmaier 408 N. Centre St.,</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Terminal Bronchial Pneumonia</u>						<u>10 days</u>	
DUE TO							
(B) <u>Cerebro-vascular accident with</u>						<u>4 month</u>	
DUE TO <u>Left hemiplegia</u>							
(C) <u>Cerebral arteriosclerosis</u>						<u>3</u>	
DUE TO <u>Generalized arteriosclerosis</u>						<u>1.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>6 Feb.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 Feb. 56</u> , 19 <u>56</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Alfred W. Oliver</u>		ADDRESS <u>M. D. Cumberland, Md.</u>		DATE SIGNED <u>7 Feb. 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9 /56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 8, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		24. FUNERAL DIRECTOR <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 10 1956

BUREAU V. 3

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01256

1256 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>02 Cumberland</u>		LENGTH OF STAY (In this place) <u>2 days</u>		TOWN <u>Cumberland</u>		TOWN <u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62 Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>313 Schley Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Carrie</u> (Middle) <u>Woodward</u> (Last) <u>Steiner</u>				(Month) <u>2</u> (Day) <u>15</u> (Year) <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/22/64</u>	9. AGE last birthday <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Kephart</u>				14. MOTHER'S MAIDEN NAME <u>Maria Woodward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient's Chart</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Generalized arteriosclerotic disease</u>						<u>year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>myocardial infarction</u>						<u>months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14, 1954</u> , to <u>July 15, 1955</u> , that I last saw the deceased alive on <u>July 14, 1955</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schneider</u>		M.D. <u>41 E. Market Street, Cumberland, Md.</u>		DATE SIGNED <u>7/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>John 17, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter L. Gandy, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u> ADDRESS <u>Cumberland, Md.</u>			

1956 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

01350

Reg. Dist. No.

1. MAJOR RESIDENCE (HOMER OR RESIDENCE)

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. OCCUPATION
8. MARITAL STATUS
9. RACE
10. COLOR
11. RELIGION
12. EDUCATION
13. SERVICE
14. SOCIAL SECURITY NO.
15. MOTHER'S MAIDEN NAME
16. FATHER'S NAME
17. DATE OF DEATH
18. TIME OF DEATH
19. CAUSE OF DEATH
20. MANNER OF DEATH
21. SIGNATURE OF DECEASED
22. SIGNATURE OF WITNESSES
23. SIGNATURE OF PHYSICIAN
24. SIGNATURE OF CLERK
25. SIGNATURE OF REGISTRAR
26. SIGNATURE OF JUDGE
27. SIGNATURE OF SHERIFF
28. SIGNATURE OF CORONER
29. SIGNATURE OF DISTRICT ATTORNEY
30. SIGNATURE OF COUNTY CLERK
31. SIGNATURE OF TOWNSHIP CLERK
32. SIGNATURE OF VILLAGE CLERK
33. SIGNATURE OF CITY CLERK
34. SIGNATURE OF COUNTY CLERK
35. SIGNATURE OF TOWNSHIP CLERK
36. SIGNATURE OF VILLAGE CLERK
37. SIGNATURE OF CITY CLERK
38. SIGNATURE OF COUNTY CLERK
39. SIGNATURE OF TOWNSHIP CLERK
40. SIGNATURE OF VILLAGE CLERK
41. SIGNATURE OF CITY CLERK
42. SIGNATURE OF COUNTY CLERK
43. SIGNATURE OF TOWNSHIP CLERK
44. SIGNATURE OF VILLAGE CLERK
45. SIGNATURE OF CITY CLERK
46. SIGNATURE OF COUNTY CLERK
47. SIGNATURE OF TOWNSHIP CLERK
48. SIGNATURE OF VILLAGE CLERK
49. SIGNATURE OF CITY CLERK
50. SIGNATURE OF COUNTY CLERK

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. RACE
9. COLOR
10. RELIGION
11. EDUCATION
12. SERVICE
13. SOCIAL SECURITY NO.
14. MOTHER'S MAIDEN NAME
15. FATHER'S NAME
16. DATE OF DEATH
17. TIME OF DEATH
18. CAUSE OF DEATH
19. MANNER OF DEATH
20. SIGNATURE OF DECEASED
21. SIGNATURE OF WITNESSES
22. SIGNATURE OF PHYSICIAN
23. SIGNATURE OF CLERK
24. SIGNATURE OF REGISTRAR
25. SIGNATURE OF JUDGE
26. SIGNATURE OF SHERIFF
27. SIGNATURE OF CORONER
28. SIGNATURE OF DISTRICT ATTORNEY
29. SIGNATURE OF COUNTY CLERK
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32. SIGNATURE OF CITY CLERK
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44. SIGNATURE OF CITY CLERK
45. SIGNATURE OF COUNTY CLERK
46. SIGNATURE OF TOWNSHIP CLERK
47. SIGNATURE OF VILLAGE CLERK
48. SIGNATURE OF CITY CLERK
49. SIGNATURE OF COUNTY CLERK
50. SIGNATURE OF TOWNSHIP CLERK

NOTATION

BUREAU V. S.

FEB 20 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01257

1276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20		d. STREET ADDRESS 194 W. Main St.,	
3. NAME OF DECEASED (Type or print) ELMER		4. DATE OF DEATH 2 27th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 - 22-1886
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) Garrett County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Steinla		14. MOTHER'S MAIDEN NAME Mary Werner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-03-4329	
17. INFORMANT 194 W. Main (widow)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 , 19 55 , to 2 20 , 19 56 , that I last saw the deceased alive on 2/20 , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Devers		ADDRESS (Street, city or town, state) Frostburg, Md.	
PHYSICIAN'S NAME (Type) John C. Devers		DATE SIGNED 3/1/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-1956	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montesant		24a. REC'D BY REGISTRAR 3-1-56	
ADDRESS Hafer Funeral Home Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Willie Murray N. Rags	

BUREAU V. S.

MAR 5 1956

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1294 CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Allegany</i>		MARYLAND		STATE <i>Pa.</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>X</i> <i>Corriganville</i>		<i>8 yrs.</i>		<i>Berlin</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i>				<i>1</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>ANNIE J. STEVANUS</i>				<i>Feb. 2, 1956</i>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED: (Specify):		8. DATE OF BIRTH: (Month) (Day) (Year)	
<i>Female</i>		<i>White</i>		<i>Widowed</i>		<i>Dec. 28, 1867</i>	
9a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:				9b. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.			
<i>House Wife</i>				<i>88</i> yrs. Months Days Hours Min.			
10a. FATHER'S NAME:				10b. KIND OF BUSINESS OR INDUSTRY:			
<i>John Server</i>				<i>Own Home</i>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<i>Somerset Co. Pa.</i>				<i>U.S.A.</i>			
13. MOTHER'S MAIDEN NAME:				14. INFORMANT & ADDRESS:			
<i>Matilda Flamm</i>				<i>Clarence M. Wincapler</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:			
<i>No</i>				<i>None</i>			
17. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<i>422.1</i>							
Immediate cause (a) <i>Chronic Myocarditis with Infarction</i>							
Antecedent causes (b) <i>Corriganville Md</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>Interval Between Onset And Death</i>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death <i>Arteriosclerosis 5 yrs</i>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<i>0</i>				<i>Arteriosclerosis</i>			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)			
<i>0</i>				<i>0</i>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
<i>0</i>				<i>0</i>			
HOW DID INJURY OCCUR?				19. <i>2-2-56</i> to <i>10-2-56</i> what I last saw the deceased			
22. I hereby certify that I attended the deceased from				23. <i>10-2-56</i> from the causes and on the date stated above.			
alive on <i>January 1, 1956</i> and that death occurred at <i>10-2-56</i>				DATE SIGNED			
SIGNATURE <i>James J. Johnson</i>				ADDRESS <i>M.D. Johnson Berlin, Pa.</i>			
24. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF			
<i>Burial</i>				<i>Feb. 5, 1956</i>			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
<i>W.O.F. Cemetery</i>				<i>Berlin, Pa.</i>			
DATE REC'D BY LOCAL REGISTRAR				FEDERAL DIRECTOR			
<i>Feb. 2, 1956</i>				<i>W.D. Johnson Berlin, Pa.</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE-A

ACAWAM-BOND

100% COTTON CONTENT

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1295 CERTIFICATE OF DEATH

01259

Reg. Dist. No. 2

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Flintstone</u>		<u>40 years</u>		TOWN <u>Flintstone</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Route 2,</u>				<u>Route 2,</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>JAMES WILLIAM STICKLEY</u>				<u>Feb. 29, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 6, 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Own farm</u>		<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles W. Stickley</u>				<u>Samantha Belle Brill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Daisy Stotler, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A)				<u>Congestive Heart Failure</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Glomerulonephritis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Atherosclerosis</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>6 mos.</u>			
				<u>2 yrs.</u>			
				<u>10 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>54</u> , to <u>Feb.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 29</u> , 19 <u>56</u> , and that death occurred at <u>6:25</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>R. R. Brown</u>				DATE SIGNED <u>3/1/56</u>			
M.D. <u>Fort Ashby, W. Va.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/1/1956</u>		<u>Stickley Cemetery</u>		<u>Flintstone, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>March 1, 1956</u>		<u>Anna L. Bender</u>		<u>William H. Kight, Cumberland, Md.</u>			

BUREAU V. S.

5 MAR 5 1956

RECEIVED

1257 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Allegany	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Cumberland	COUNTY	Allegany
TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	Luke
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Allegany County Infirmary	STREET ADDRESS	Cromwell Street
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Robert Corder Stump		February 11, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Single	8/17/1883
9. AGE last birthday		10. IF UNDER 1 YEAR	
72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired - Superintendent		Luke Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jacob Stump		Elizabeth Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		214-03-5004	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Allegany County Infirmary Records		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19a. DATE OF OPERATION	
592X IMMEDIATE CAUSE (A)		19b. MAJOR FINDINGS OF OPERATION	
ANTECEDENT CAUSE(S) DUE TO		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
(C)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
19a. DATE OF OPERATION		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
19b. MAJOR FINDINGS OF OPERATION		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Jan. 21, 1956, to Feb. 11, 1956, that I last saw the deceased alive on Feb. 11, 1956, and that death occurred at 11:00 A.M. from the causes and on the date stated above.	
SIGNATURE		DATE SIGNED	
James E. McLean M.D.		2-11-56	
ADDRESS (Street, city, town, state)		49 Green St. Westernport, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
Burial		Feb. 14/56	
DATE THEREOF		REGISTRAR'S SIGNATURE	
Feb. 14/56		Winter R. Frank, M.D.	
NAME OF CEMETERY OR CREMATORY		25. FUNERAL DIRECTOR'S SIGNATURE	
Philos		W. Harold Fullock	
LOCATION (City, town, or county) (State)		ADDRESS	
Westernport, Md.		Piedmont, W. Va.	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

155 CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. DATE

11. TIME

12. SEX

13. OCCUPATION

14. PLACE OF BIRTH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. PLACE OF DEATH

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF REGISTRAR

BUREAU V. 3

FEB 15 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01261

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Mt. Savage</u>		<u>72 years</u>		TOWN <u>Mt. Savage</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>/</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Mary</u>		<u>Ellen</u>		<u>Tansey</u>		<u>Feb.</u> <u>23</u> <u>19 56</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH: <u>Nov. 15-1883</u>	
9. AGE last birthday: <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>clerk</u>		11. BIRTHPLACE (State or foreign country): <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John L Tansey</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Mary Malloy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Miss Martha Reagon, Mt. Savage, Md.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u> Immediate cause (a)..... <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b)..... <u>Coronary sclerosis also had</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <u>Osteomyelitis of the spine</u>				<u>sudden</u> <u>?</u> <u>several years.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> <u>H.V. Deming M.D.</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb. 23-1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2-27-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick's</u>	
LOCATION (City, town, or county) (State) <u>Mt. Savage - Alleg - Md.</u>					
DATE REC'D BY LOCAL REG. <u>2-26-56</u>		REGISTRAR'S SIGNATURE <u>Veronica M. Smith</u>		24. FUNERAL DIRECTOR <u>Joseph R. Dunc</u> ADDRESS	

RECEIVED
FEB 28 1956
BUREAU V. S.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1297 CERTIFICATE OF DEATH

01262

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>McCoole</u>		<u>77 yrs.</u>		TOWN <u>McCoole</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12 Queen St.</u>				STREET ADDRESS (If rural give location) <u>12 Queen St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles Edward Tharp</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>1</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 8, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ry. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Ry. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>McCoole, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Braxton Tharp</u>				14. MOTHER'S MAIDEN NAME <u>Susan Ruckman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-05-9861</u>		17. INFORMANT & ADDRESS <u>12 Queen St., Mrs. C. E. Tharp, McCoole, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>15 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>9 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Coronary insufficiency</u>						<u>9 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 1, 19 56</u> , to <u>Feb. 1, 19 56</u> , that I last saw the deceased alive on <u>Feb. 1, 19 56</u> , and that death occurred at <u>1:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Wm. S. Coppin</u>				DATE SIGNED <u>M.D. 30 N. Main St., Keyser, West Virginia</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Queens Point Cem.</u>		LOCATION (City, town, or county) (State) <u>Keyser, W. Va.</u>	
24. REC'D BY REGISTRAR <u>2-2-56</u>		REGISTRAR'S SIGNATURE <u>Therese C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. W. Markwood</u>		ADDRESS <u>Keyser, W. Va.</u>	

1907 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

11305

1. NAME OF DECEASED

Alphonse

MARYLAND

Alphonse

Alphonse

IS BORN AT

IN FRANCE AT

CERTIFICATE

EDWARD

DATE OF DEATH

1907

VA

Alphonse

Alphonse

W. J. HARRISON, M.D.

JOHN HARRISON

1907-08-01

JOHN HARRISON, M.D.

TO THE MEDICAL EXAMINER

Alphonse

Alphonse

Alphonse

BUREAU V. S.

FEB 6 1908

RECEIVED

RECEIVED

RECEIVED
FEB 6 1908
BUREAU V. S.

1258

01263

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland LENGTH OF STAY (in this place) 50 Yrs.HOSPITAL OR INSTITUTION OR STREET ADDRESS 115 N. Cedar St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY AlleganyCITY (If outside corporate limits write RURAL and give nearest town) OR TOWN CumberlandSTREET ADDRESS (If rural, give location) 115 N. Cedar St.

3. NAME OF DECEASED:

(First) William (Middle) Henry (Last) Trail4. DATE OF DEATH (Month) (Day) (Year) Feb. 2 19 56

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

widower

8. DATE OF BIRTH:

Sept. 23-1873

9. AGE last birthday:

82 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Retired Engineer

10b. KIND OF BUSINESS OR INDUSTRY:

B&O R.Ry.

11. BIRTHPLACE (State or foreign country):

Clapper, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Barton F. Trail

14. MOTHER'S MAIDEN NAME:

Margaret - Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

705-07-6883

17. INFORMANT & ADDRESS:

(daughter) Mrs. Marie Cole, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) Coronary occlusion

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerosis

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

sudden

?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

0

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐H. V. Deming M.D. H. V. Deming M.D. M. D.

Feb. 2-1956

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial
DATE REC'D BY LOCAL REG. Feb. 3, 1956

DATE THEREOF

Feb. 6, 1956

NAME OF CEMETERY OR CREMATORY

St. Mary's Basilica

LOCATION (City, town, or county) (State)

Cumberland, Maryland

REGISTRAR'S SIGNATURE

Walter R. Frank, M.D.

FUNERAL DIRECTOR

James F. Scarfelli

ADDRESS

"

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1900

RECEIVED

1259

CERTIFICATE OF DEATH

01264

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 62 Sacred Heart Hosp.				d. STREET ADDRESS 236 Paca St.,			
3. NAME OF DECEASED (Type or print) First HOWARD Middle WILLIAM Last WALTERS				4. DATE OF DEATH Month Feb. Day 16, Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1900	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) East Greenville, Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME William Walters				14. MOTHER'S MAIDEN NAME Ella Ickes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Elva Walters				Address 236 Paca St., Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial asthma DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week 14 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/25/49 , 19____, to 2/16/ , 19 56 , that I last saw the deceased alive on 2/16 , 19 56 , and that death occurred at 11:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ralph W. Ballin M.D. 62 Greene St., Cumberland, Md. 2/20/56 ACTUAL SIGNATURE NAME (Type) Ralph W. Ballin 62 Greene St., Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Feb 20, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. ... M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01265

1260 CERTIFICATE OF DEATH

Item 9, FilmG192 2-15-56 et

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>W. Va.</u>		COUNTY <u>Mineral</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Cumberland</u>		<u>3 days</u>		TOWN <u>Springfield Rural</u>		<u>85X.3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS <u>Rt. # 1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William Showers Ward</u>				<u>2 6 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Separated</u>	<u>10/30/68</u>	<u>68 87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>Farmer (Self)</u>		<u>W. Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John C. Ward</u>				<u>Rachel Kerns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Laura Dyche, Martinsburg, W. Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>4221</u> IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cerebral Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/3/56</u>, 19<u>56</u>, to <u>2/5/56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/5/56</u>, 19<u>56</u>, and that death occurred at <u>4:20 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Dr. G. O. Himmelwright</u>				ADDRESS (Street, city, town, state) <u>133 Va. Ave., Cumberland, Md.</u>		DATE SIGNED <u>2/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 8 1956</u>		<u>Dans Run Cemetery</u>		<u>(Near) Fort Ashby, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 7, 1956</u>		<u>Walter R. Franz, M.D.</u>		<u>Ralph N. Guthrie</u>		<u>Springfield, W. Va.</u>	

Dr. G. O. Himmelwright

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 18 CERTIFICATE OF DEATH

Reg. Dist. No.

1. FULL RESIDENCE (Street or R.F.D.)

2. SEX

3. AGE

4. OCCUPATION

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF CLERK

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF CLERK

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF DISTRICT ATTORNEY

26. SIGNATURE OF CLERK

27. SIGNATURE OF JUDGE

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DISTRICT ATTORNEY

30. SIGNATURE OF CLERK

31. SIGNATURE OF JUDGE

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF DISTRICT ATTORNEY

34. SIGNATURE OF CLERK

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF DISTRICT ATTORNEY

38. SIGNATURE OF CLERK

39. SIGNATURE OF JUDGE

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF DISTRICT ATTORNEY

42. SIGNATURE OF CLERK

43. SIGNATURE OF JUDGE

44. SIGNATURE OF SHERIFF

45. SIGNATURE OF DISTRICT ATTORNEY

46. SIGNATURE OF CLERK

47. SIGNATURE OF JUDGE

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF DISTRICT ATTORNEY

50. SIGNATURE OF CLERK

51. SIGNATURE OF JUDGE

52. SIGNATURE OF SHERIFF

53. SIGNATURE OF DISTRICT ATTORNEY

54. SIGNATURE OF CLERK

55. SIGNATURE OF JUDGE

56. SIGNATURE OF SHERIFF

57. SIGNATURE OF DISTRICT ATTORNEY

58. SIGNATURE OF CLERK

59. SIGNATURE OF JUDGE

60. SIGNATURE OF SHERIFF

61. SIGNATURE OF DISTRICT ATTORNEY

62. SIGNATURE OF CLERK

63. SIGNATURE OF JUDGE

64. SIGNATURE OF SHERIFF

65. SIGNATURE OF DISTRICT ATTORNEY

66. SIGNATURE OF CLERK

67. SIGNATURE OF JUDGE

68. SIGNATURE OF SHERIFF

69. SIGNATURE OF DISTRICT ATTORNEY

70. SIGNATURE OF CLERK

71. SIGNATURE OF JUDGE

72. SIGNATURE OF SHERIFF

73. SIGNATURE OF DISTRICT ATTORNEY

74. SIGNATURE OF CLERK

75. SIGNATURE OF JUDGE

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF DISTRICT ATTORNEY

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79. SIGNATURE OF JUDGE

80. SIGNATURE OF SHERIFF

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107. SIGNATURE OF JUDGE

108. SIGNATURE OF SHERIFF

109. SIGNATURE OF DISTRICT ATTORNEY

110. SIGNATURE OF CLERK

111. SIGNATURE OF JUDGE

112. SIGNATURE OF SHERIFF

113. SIGNATURE OF DISTRICT ATTORNEY

114. SIGNATURE OF CLERK

115. SIGNATURE OF JUDGE

116. SIGNATURE OF SHERIFF

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118. SIGNATURE OF CLERK

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126. SIGNATURE OF CLERK

127. SIGNATURE OF JUDGE

128. SIGNATURE OF SHERIFF

129. SIGNATURE OF DISTRICT ATTORNEY

130. SIGNATURE OF CLERK

131. SIGNATURE OF JUDGE

132. SIGNATURE OF SHERIFF

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134. SIGNATURE OF CLERK

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139. SIGNATURE OF JUDGE

140. SIGNATURE OF SHERIFF

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144. SIGNATURE OF SHERIFF

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146. SIGNATURE OF CLERK

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148. SIGNATURE OF SHERIFF

149. SIGNATURE OF DISTRICT ATTORNEY

150. SIGNATURE OF CLERK

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153. SIGNATURE OF DISTRICT ATTORNEY

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159. SIGNATURE OF JUDGE

160. SIGNATURE OF SHERIFF

161. SIGNATURE OF DISTRICT ATTORNEY

162. SIGNATURE OF CLERK

163. SIGNATURE OF JUDGE

164. SIGNATURE OF SHERIFF

165. SIGNATURE OF DISTRICT ATTORNEY

166. SIGNATURE OF CLERK

167. SIGNATURE OF JUDGE

168. SIGNATURE OF SHERIFF

BUREAU V. S.

FEB 9 1956

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allogany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allogany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lenacoring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lenacoring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cecelia			First	Middle	Last	4. DATE OF DEATH Month February Day 27 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 6, 1868		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hansel				14. MOTHER'S MAIDEN NAME Barnard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. William Weir Address Lenacoring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 9-10 mo 4 yr 5-6 yr							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1952</u> to <u>27 Feb 1956</u> , that I last saw the deceased alive on <u>26 Feb 1956</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lenacoring, Md</u> DATE SIGNED <u>2-28-56</u> ACTUAL SIGNATURE <u>George Richards</u> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Philes Cometary		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lenacoring, Md.				24a. REC'D BY REGISTRAR DATE 3-1-56		24b. REGISTRAR'S SIGNATURE Jannette M. Boal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Roman Catholic		Married		Teacher		Heart Disease		March 10, 1956		Home		John Doe, M.D.		John Doe, Registrar	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Filing	
New York		Jan 1, 1911		Mar 1, 1955		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956		Mar 10, 1956	

BUREAU V. S.
MAR 5 1956
RECEIVED

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Roman Catholic		Married		Teacher		Heart Disease		March 10, 1956		Home		John Doe, M.D.		John Doe, Registrar	

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01267

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland COUNTY Allegany		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN Westernport	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN Westernport	
TOWN Cumberland		2/10/55		STREET ADDRESS (If rural give location)		Box 255	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS Box 255			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Mary (Middle) Virginia (Last) Westfall				(Month) February (Day) 7 (Year) 1956			
5. SEX	6. RACE OR COLOR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widow	7/10/1874	81 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Moorefield, W. Va.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Nathanial Kykendall				Mary Jane Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A)				Coronary Sclerosis			
ANTECEDENT CAUSE(S) DUE TO				Chronic Myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)				Cerebral arteriosclerosis			
DUE TO (C)				Chronic Nephritis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				?			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 10/1955 , to Feb. 7/1956 , that I last saw the deceased alive on Feb. 6/1956 , and that death occurred at 1:30 a.m. from the causes and on the date stated above.							
SIGNATURE James E. Whean				ADDRESS (Street, city, town, state) 49 Greene St.		DATE SIGNED 2-7-56	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 9, 1956		Philos Cemetery		Westernport, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Feb. 8, 1956		Walter R. Frank, M.D.		E. S. Boal		"	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

01303

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. OCCUPATION Teacher		5. MARITAL STATUS Married		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH 10/15/55		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESSES [Signature]		15. SIGNATURE OF REGISTRAR [Signature]	
16. DATE OF REGISTRATION 10/16/55		17. TIME OF REGISTRATION 10:00 AM		18. PLACE OF REGISTRATION Baltimore	
19. NAME OF REGISTRAR John Doe		20. NAME OF PHYSICIAN John Doe		21. NAME OF WITNESSES John Doe	
22. NAME OF DECEASED John Doe		23. NAME OF DECEASED John Doe		24. NAME OF DECEASED John Doe	
25. NAME OF DECEASED John Doe		26. NAME OF DECEASED John Doe		27. NAME OF DECEASED John Doe	
28. NAME OF DECEASED John Doe		29. NAME OF DECEASED John Doe		30. NAME OF DECEASED John Doe	
31. NAME OF DECEASED John Doe		32. NAME OF DECEASED John Doe		33. NAME OF DECEASED John Doe	
34. NAME OF DECEASED John Doe		35. NAME OF DECEASED John Doe		36. NAME OF DECEASED John Doe	
37. NAME OF DECEASED John Doe		38. NAME OF DECEASED John Doe		39. NAME OF DECEASED John Doe	
40. NAME OF DECEASED John Doe		41. NAME OF DECEASED John Doe		42. NAME OF DECEASED John Doe	
43. NAME OF DECEASED John Doe		44. NAME OF DECEASED John Doe		45. NAME OF DECEASED John Doe	
46. NAME OF DECEASED John Doe		47. NAME OF DECEASED John Doe		48. NAME OF DECEASED John Doe	
49. NAME OF DECEASED John Doe		50. NAME OF DECEASED John Doe		51. NAME OF DECEASED John Doe	
52. NAME OF DECEASED John Doe		53. NAME OF DECEASED John Doe		54. NAME OF DECEASED John Doe	
55. NAME OF DECEASED John Doe		56. NAME OF DECEASED John Doe		57. NAME OF DECEASED John Doe	
58. NAME OF DECEASED John Doe		59. NAME OF DECEASED John Doe		60. NAME OF DECEASED John Doe	
61. NAME OF DECEASED John Doe		62. NAME OF DECEASED John Doe		63. NAME OF DECEASED John Doe	
64. NAME OF DECEASED John Doe		65. NAME OF DECEASED John Doe		66. NAME OF DECEASED John Doe	
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73. NAME OF DECEASED John Doe		74. NAME OF DECEASED John Doe		75. NAME OF DECEASED John Doe	
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85. NAME OF DECEASED John Doe		86. NAME OF DECEASED John Doe		87. NAME OF DECEASED John Doe	
88. NAME OF DECEASED John Doe		89. NAME OF DECEASED John Doe		90. NAME OF DECEASED John Doe	
91. NAME OF DECEASED John Doe		92. NAME OF DECEASED John Doe		93. NAME OF DECEASED John Doe	
94. NAME OF DECEASED John Doe		95. NAME OF DECEASED John Doe		96. NAME OF DECEASED John Doe	
97. NAME OF DECEASED John Doe		98. NAME OF DECEASED John Doe		99. NAME OF DECEASED John Doe	
100. NAME OF DECEASED John Doe		101. NAME OF DECEASED John Doe		102. NAME OF DECEASED John Doe	

BUREAU V. S.

FEB 9 1956

RECEIVED

1262

01268

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cumberland, Md.</u>		<u>12 yrs.</u>		TOWN <u>(1) Corrigansville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Sacred Heart Hospital</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Robert</u>		(Middle) <u>Arthur</u>		(Last) <u>Whitehair</u>		(Month) (Day) (Year) <u>Feb. 15 19 56</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Sept. 8-1922</u>	
9. AGE last birthday: <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Cumberland Cement & Supply Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Morse Shoe Run, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Boy Whitehair</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Snyder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>235-38-9679</u>		17. INFORMANT & ADDRESS: <u>Md. (wife) Glenna Whitehair, Corrigansville</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>914.3</u> Immediate cause (a) <u>Electrocution</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c) <u>None</u>				<u>sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Sand Plant</u>		21c. (City or town) (County) (State) <u>near-Corrigansville-Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb. 15-1956 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Trying to repair a short circuit, took hold of live wire.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H.V. Deming M.D.</u>		<u>Feb. 16-1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Feb. 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Belmont Burial Park</u>	
LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REG. <u>Feb. 17, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		<u>Harvey R. Feigley, Synderman, Penna.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegany</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cumberland</u>	(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>B&O.R.Ry.tracks near Scale House, Kelley-S.Tire Co.</u>			STREET ADDRESS <u>39 New Hampshire Ave.</u>		
3. NAME OF DECEASED: (Type or Print) <u>Frank Lester Wilson Sr.</u>			4. DATE OF DEATH <u>Feb. 6 19 56</u>		
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>May 20-1901</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired) <u>Brakeman</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Tailroading</u>		
11. BIRTHPLACE (State or foreign country): <u>Republic, Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>William F. Wilson</u>			14. MOTHER'S MAIDEN NAME: <u>Elizabeth E. Proviance</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			16. SOCIAL SECURITY No.: <u>705-09-3702</u>		
(If Yes, give war or dates of service)			17. INFORMANT & ADDRESS: <u>(wife) Lavera Wilson, Cumberland, Md.</u>		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Shock & exsanguination</u> DUE TO Antecedent cause(s) (b) <u>Disemboweled & fractured Spine, (complete)</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Left hand practically severed at wrist.</u>			sudden		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF streets, office, bldg., etc., INJURY <u>B&O.R.Ry.</u>		21c. (City or town) (County) (State) <u>Cumberland Allegany Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb. 6-1956 A. M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shifting cars, uncoupled train & caught between two</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Deming M.D.</u>			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Feb. 6-1956</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>			24. FUNERAL DIRECTOR <u>James F. Scarbelle, Cumberland, Md.</u>		
DATE THEREOF <u>Feb. 9 1956</u>			LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>		
DATE REC'D BY LOCAL REG. <u>Feb. 7, 1956</u>			REGISTRAR'S SIGNATURE <u>Walter R. Brant, M.D.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 9 1956

BUREAU V. 8

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01270

1299

CERTIFICATE OF DEATH

Reg. Dist. No. *2*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>near Flintstone, rural</u>		<u>3</u> yrs <u>1</u> mo		TOWN <u>near Flintstone, rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #1</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIAM MARSHALL WOLFORD</u>				<u>Feb. 11, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 9, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Mt. Merchant</u>		<u>Martins Mt. Inn</u>		<u>Flintstone, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>SAMUEL WOLFORD</u>				<u>AMANDA WILLISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>220-30-8668</u>		<u>Mt. 1 Thos. R. Wolford, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>due to an</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Coronary atherosclerosis</u>							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 4, 1956</u> , to <u>Feb. 11, 1956</u> , that I last saw the deceased alive on <u>Feb. 4, 1956</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. Bridges</u>		M.D. <u>55 Green St. Cumberland, Md.</u>		DATE SIGNED <u>Feb. 15, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 15, 1956</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 15, 1956</u>		<u>Miss L. Bender</u>		<u>John J. Hafer</u>		<u>Cumberland, Md.</u>	

01271

1264

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital. The attending physician, _____, filled in by the funeral director, _____, **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE		MARYLAND		b. COUNTY		ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
OCTAVIA						WYATT		2		23 1956	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10/1/79		76 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Own Home		WEST VIRGINIA, Belington		UNITED STATES					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
LEVI CROSS				ANGELINE PRICE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		None		OLD CHART MRS ANGELA HAMILTON, ROUTE #6		Cumberland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260x</u> DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Generalized Atherosclerosis, Bilateral Optic atrophy</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>20 yr.</u> <u>20 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
		none		none 19		While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		none		none	
21. I certify that I attended the deceased from <u>April 4, 1979</u> to <u>Feb 23, 1976</u> , that I last saw the deceased alive on <u>Feb 23, 1976</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>J. P. Hallinan MD</u>				ADDRESS (Street, city or town, state) <u>146 Bedford St. Cumberland Md.</u>				DATE SIGNED <u>7/13/76</u>			
PHYSICIAN'S NAME (Type) <u>J. P. HALLINAN M.D.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)					
Burial		Feb. 25, 1956		Stringtown, Cemetery		Belington, West Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Hafer, Cumberland, Maryland</u>								DATE <u>25, 1956</u>		<u>W. L. Harts, M.D.</u>	

CERTIFICATE OF DEATH

1954

DATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 29 1954

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01272

1265 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland, Md.</u>		LENGTH OF STAY (in this place) <u>12 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>531 Lowell, Ave.</u>				STREET ADDRESS (If rural give location) <u>531 Lowell, Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Alvin J. Yoder</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>16</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Aug. 15, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Hardware Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jonas M. Yoder</u>				14. MOTHER'S MAIDEN NAME <u>Mary Beachy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-24-1513</u>		17. INFORMANT & ADDRESS <u>Mrs Dorothy Yoder Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute myocardial infarction</u>						<u>1 da.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary insufficiency</u>						<u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic hypotension</u>						<u>1 yr.</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>Apr. 4, 19 55</u> , to <u>Feb. 16, 19 56</u> , that I last saw the deceased alive on <u>Feb. 16, 19 56</u> , and that death occurred at <u>9.40P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. Lee Silcox M.D.</u>		ADDRESS (Street, city, town, state) <u>140 Bedford St., Cumberland, Md.</u>		DATE SIGNED <u>2/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Meyersdale, Pa.</u>	
24. REC'D BY REGISTRAR <u>Feb. 19, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Grant, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox- Cumberland, Md.</u>			

STATE OF MARYLAND
DEPARTMENT OF HEALTH-BALTIMORE
1956 CERTIFICATE OF DEATH

Form 10-56

1. PLACE OF DEATH

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. SEX

13. AGE

14. RACE

15. OCCUPATION

16. CAUSE OF DEATH

17. MANNER OF DEATH

18. DATE OF DEATH

19. TIME OF DEATH

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. SEX

23. AGE

24. RACE

25. OCCUPATION

26. CAUSE OF DEATH

27. MANNER OF DEATH

28. DATE OF DEATH

29. TIME OF DEATH

BUREAU V. S.

FEB 21 1956

RECEIVED

1266 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>2 days</u>		TOWN <u>Honaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Joyce Lynn Yommer</u>				4. DATE OF DEATH <u>Feb. 20 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>9/15/55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>5</u> yrs.		IF UNDER 1 YEAR <u>5</u> Months <u>5</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harold Yommer</u>		14. MOTHER'S MAIDEN NAME <u>Betty Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Pt's chart--Mother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>754.0 Anoxia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2d.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebrovascular of Left Lung</u>				<u>2d.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Tetralogy of Fallot</u>				<u>5 mo.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20 Jan</u> , 19 <u>56</u> , to <u>20 Feb</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>20 Feb</u> , 19 <u>56</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George Richards</u>				ADDRESS (Street, city, town, state) <u>Honaconing, Ind</u>		DATE SIGNED <u>21 Feb '56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 24, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moscow Cemetery</u>		LOCATION (City, town, or county) (State) <u>Moscow, MD.</u>	
24. REC'D BY REGISTRAR <u>Feb. 24, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Leavitt, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Rich</u>		ADDRESS <u>honaconing, MD</u>	

2061251404

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

11938

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1958 CERTIFICATE OF DEATH

NEW DATE, MD

1. UNDERSTANDING OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

MARYLAND

4. SEX

5. DATE OF BIRTH

6. RACE

7. OCCUPATION

8. PLACE OF BIRTH

9. MARITAL STATUS

10. CAUSE OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF TOWNSHIP CLERK

24. SIGNATURE OF VOTING CLERK

25. SIGNATURE OF POLLING CLERK

26. SIGNATURE OF CANVASSER

27. SIGNATURE OF BALLOT BOX CLERK

28. SIGNATURE OF BALLOT CLERK

29. SIGNATURE OF BALLOT BOX CLERK

30. SIGNATURE OF BALLOT CLERK

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BUREAU V. M.

FEB 27 1956

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